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Acronym Glossary

Acronym	Definition
ACA	Affordable Care Act
ACC	Accountable Care Collaborative
ACE	Acute Care Episode
ACO	Accountable Care Organization
ACT	Advancing Care Together
ADHD	Attention-Deficit/Hyperactivity Disorder
ADT	Automatic Data Transfer
AHEC	Area Health Education Center
AHRQ	Agency for Healthcare Research and Quality
AND	Aid for Needy and Disabled
ARRA	American Recovery and Reinvestment Act
APCD	All Payer Claims Database
ARIES	Automated Report Information Exchange System
ASTHO	Association of State and Territorial Health Officials
AUDIT	Alcohol Use Disorders Identification Test
BH	Behavioral Health
BHO	Behavioral Health Organization
BHP	Behavioral Health Provider
BIDM	Business Intelligence Data Management
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance Survey
CACHIE	Colorado Associated Community Health Information Exchange
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CALPHO	Colorado Association of Local Public Health Officials
CAVU	The CAVU Corporation

CBHC	Colorado Behavioral Healthcare Council
CBMS	Colorado Benefits Management System
CCAR	Colorado Client Assessment Record
CCD	Continuity of Care Documents
CCHS	Colorado Child Health Survey
CCISS	Colorado Client Information Sharing System
CCR	Colorado Code of Regulations
CCT	Community Care Team
CDC	Centers for Disease Control and Prevention
CDHS	Colorado Department of Human Services
CDPHE	Department of Public Health and Environment
CDS	Clinical Decisions Support
CEDR	Comprehensive Epidemiologic Data Resource
CFC	Community First Choice
CFR	Code of Federal Regulations
CHA	Colorado Hospital Association
CHAPS	Colorado Health Assessment and Planning System
CHAS	Colorado Health Access Survey
CHP	Children Health Plan
CHIPRA	Children's Health Insurance Reauthorization Act
CHW	Community Health Workers
CHW/PN	Community Health Workers/Patient Navigator
CIIS	Colorado Immunization Information System
CIVHC	Center for Improving Value in Health Care
CLAG	Community Living Advisory Group
CMHC	Community Mental Health Centers
CMMI	Center for Medicare and Medicaid Innovations
COHSS	Colorado Oral Health Surveillance System
CORHIO	Colorado Regional Health Information Organization
COVIS	Colorado Vital Information System

CPA	Colorado Prevention Alliance
CPC	Comprehensive Primary Care
CPT	Current Procedural Terminology
COOW	Communities Putting Prevention to Work
CRS	Colorado Revised Statutes
CTN	Colorado Telehealth Network
CUSOM	University of Colorado School of Medicine
DACODS	Drug and Alcohol Coordinated Data System
DHS	Department of Human Services
DOC	Department of Corrections
DOC-CHP	Correctional Health Partners
DORA	Department of Regulatory Agencies
DRG	Diagnosis Related Group
DSM	Diagnostic and Statistical Manual
ECHO	Extension for Community Healthcare Outcomes
E H R	Electronic Health Record
EMR	Electronic Medical Record
ER	Emergency Room
FeHITO	Federation of Health Information Technology Organizations
FFP	Federal Financial Participation
FFS	Fee for Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
FTE	Full-Time Equivalent (Employee)
FY	Fiscal Year
GAD	Generalized Anxiety Disorder
GSP	Gross State Product
HAS	Health Savings account
HB	House Bill
HCAA	Health Care Affordability Act

HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCPF	Department of Health Care Policy and Financing
HDHP	high deductible health plan
HEDIS	Healthcare Effectiveness Data and Information Set
HES	Health Extension System
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HISP	Health Information Service Provider
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HIV	Human Immunodeficiency Virus
HMO	Health Maintained Organization
HPSA	Health Provider Shortage Areas
HRSA	Health Research and Service Administration
HTC	Healthy Transitions Colorado
IDE	Intelligent Data Entry
I H S	Indian Health Service
IPA	Independent Practice Associations
IRTS	Interdisciplinary Rural Training and Service Program
IT	Information Technology
K-12	Kindergarten through 12th grade
KPI	Key Performance Indicator
LAC	Certified/Licensed Addiction Counselor
LAUNCH	Linking Actions for Unmet Needs in Children's Health
LCSW	Licensed Clinical Social Worker
LDL	Low Density Lipoprotein
LEP	Limited English Proficient
LPH	Local Public Health
LMFT	Licensed Marriage and Family Therapist

LPC	Licensed Professional Counselor
LPHA	Local Public Health Agencies
LTSS	Long Term Supports and Services
MCO	Managed Care Organizations
MH/SA	Mental Health/Substance Abuse
MHFA	Mental Health First Aid
MHPSA	Mental Health Professional Shortage Areas
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MSO	Management Services Organizations
MU	Meaningful Use
NACCHO	National Association of County and City Health
NCCHP	Northwest Colorado Community Health Partnership
NCHA	North Colorado Health Alliance
NCQA	National Committee for Quality Assurance
NPHII	National Public Health Improvement Initiative
NQF	National Quality Forum
OB	Obstetrics
OB-GYN	Obstetrics and Gynecology
OBH	Office of Behavioral Health
OIT	Office of Information Technology
ORILE	Offender Release of Information to Law Enforcement
PAM	Patient Action Measures
PATH	Projects for Assistance in Transition from Homelessness
PCCM	Primary Care Case Management
PCMH	Patient-Centered Medical Home
PCMP	Primary Care Medical Provider
PDMP	Prescription Drug Monitoring Program
PDSA	Plan Do Study Act
PEAK	Program Eligibility and Application Kit

PH HIE	Public Health Information Exchange Steering Committee
PHI	Protected Health Information
PHQ	Patient Health Questionnaire
PHR	Personal Health Record
PICS	Promoting Integrated Care Sustainability
P.L.	Public Law
PMCP	Primary Medical Care Provider
PMPM	Per Member Per Month
PN	Patient Navigator
PPACA	Patient Protection and Affordable Care Act
PTSD	Post-Traumatic Stress Disorder
QHN	Quality Health Network
QI	Quality Improvement
RCCO	Regional Care Collaborative Organizations
RE-AIM	Reach Effectiveness Adoption Implementation Maintenance
RHC	Rural Healthcare Centers
RHIT/RHIA	Registered Health Information Tech/Administrator
RISE	Rehabilitation Information System for Employment
RMHP	Rocky Mountain Health Plans
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Association
SB	Senate Bill
SDAC	Statewide Data Analytics Contractor
SHAPE	Sustaining Healthcare Across integrated Primary Care Efforts
SHIP	State Health Innovation Plan
SIM	State Innovative Model
SPMI	Severe and Persistent Mental Illness
SSI	Supplemental Security Income
SSDI	Social Security Disability Insurance

SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
TPA	Third Party Administrators
UMUHC	Ute Mountain Ute Health Center
WIC	Women, Infants and Children Regional Program

Glossary

Access

The ability to get needed medical care and services.¹

Accreditation

An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures and performance by an external organization ("accrediting body") to ensure that it is meeting predetermined criteria. It usually involves both on- and off-site surveys.

Actual Charge

The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves.

Additional Benefits

Health care services not covered by Medicare and reductions in premiums or cost sharing for Medicare-covered services. Additional benefits are specified by the Medicare Advantage (MA) Organization and are offered to Medicare beneficiaries at no additional premium. Those benefits must be at least equal in value to the adjusted excess amount calculated in the ACR. An excess amount is created when the average payment rate exceeds the adjusted community rate (as reduced by the actuarial value of coinsurance, copayments, and deductibles under Parts A and B of Medicare). The excess amount is then adjusted for any contributions to a stabilization fund. The remainder is the adjusted excess, which will be used to pay for services not covered by Medicare and/or will be used to reduce charges otherwise allowed for Medicare-covered services. Additional benefits can be subject to cost sharing by plan enrollees. Additional benefits can also be different for each MA plan offered to Medicare beneficiaries.

Administrative Code Sets

¹All entries from: <http://www.cms.gov/apps/glossary/default.asp?Letter=ALL&Language=English> unless otherwise noted

Code sets that characterize a general business situation, rather than a medical condition or service. Under HIPAA, these are sometimes referred to as non-clinical or non-medical code sets. Compare to medical code sets.

Administrative Costs

A general term that refers to Medicare and Medicaid administrative costs, as well as CMS administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-CMS administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. CMS administrative costs are the costs of operating CMS (e.g., salaries and expenses, facilities, equipment, rent and utilities, etc.). These costs are reflected in the Program Management account.

Administrative Data

This refers to information that is collected, processed, and stored in automated information systems. Administrative data include enrollment or eligibility information, claims information, and managed care encounters. The claims and encounters may be for hospital and other facility services, professional services, prescription drug services, laboratory services, and so on.

Admission Date

The date the patient was admitted for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits.

Advance Directive

Written ahead of time, a health care advance directive is a written document that says how you want medical decisions to be made if you lose the ability to make decisions for yourself. A health care advance directive may include a Living Will and a Durable Power of Attorney for health care.

Allowed Charge

Individual charge determined by a carrier for a covered SMI medical service or supply.

Ambulatory Care

All types of health services that do not require an overnight hospital stay.

Ambulatory Surgical Center

A place other than a hospital that does outpatient surgery. At an ambulatory (in and out) surgery center, you may stay for only a few hours or for one night.

Ancillary Services

Professional services by a hospital or other inpatient health program. These may include x-ray, drug, laboratory, or other services.

Appeal

An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if Medicare doesn't pay for an item or service you think you should be able to get. There is a specific process that your Medicare Advantage Plan or the Original Medicare Plan must use when you ask for an appeal.

Appeal Process

The process you use if you disagree with any decision about your health care services. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can have the initial Medicare decision reviewed again. If you are in the Original Medicare Plan, your appeal rights are on the back of the Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) that is mailed to you from a company that handles bills for Medicare. If you are in a Medicare managed care plan, you can file an appeal if your plan will not pay for, or does not allow or stops a service that you think should be covered or provided. The Medicare managed care plan must tell you in writing how to appeal. See your plan's membership materials or contact your plan for details about your Medicare appeal rights.

Approved Amount

The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes called the "Approved Charge."

Area Agency on Aging (AAA)

State and local programs that help older people plan and care for their life-long needs. These needs include adult day care, skilled nursing care/therapy, transportation, personal care, respite care, and meals.

Assessment

The gathering of information to rate or evaluate your health and needs, such as in a nursing home.

Balance Billing

A situation in which Private Fee-for-Service Plan providers (doctors or hospitals) can charge and bill you 15% more than the plan's payment amount for services.

Basic Benefits

Basic Benefits includes both Medicare-covered benefits (except hospice services) and additional benefits.

Benchmark

A benchmark is sustained superior performance by a medical care provider, which can be used as a reference to raise the mainstream of care for Medicare beneficiaries. The relative definition of superior will vary from situation to situation. In many instances an appropriate benchmark would be a provider that appears in the top 10% of all providers for more than a year.

Beneficiary

The name for a person who has health care insurance through the Medicare or Medicaid program.

Benefits

The money or services provided by an insurance policy. In a health plan, benefits are the health care you get.

Benefits Description (Plan)

The scope, terms and/or condition(s) of coverage including any limitation(s) associated with the plan provision of the service.

Capitation

A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan member's health care services for a certain length of time.

Care Plan

A written plan for your care. It tells what services you will get to reach and keep your best physical, mental, and social well-being.

Caregiver

A person who helps care for someone who is ill, disabled, or aged. Some caregivers are relatives or friends who volunteer their help. Some people provide caregiving services for a cost.

Case Management

A process used by a doctor, nurse, or other health professional to manage your health care. Case managers make sure that you get needed services, and track your use of facilities and resources.

Case Manager

A nurse, doctor, or social worker who arranges all services that are needed to give proper health care to a patient or group of patients.

Claim

A claim is a request for payment for services and benefits you received. Claims are also called bills for all Part A and Part B services billed through Fiscal Intermediaries. "Claim" is the word used for Part B physician/supplier services billed through the Carrier.

Clinical Performance Measure

This is a method or instrument to estimate or monitor the extent to which the actions of a health care practitioner or provider conform to practice guidelines, medical review criteria, or standards of quality.

Cohort

A population group that shares a common property, characteristic, or event, such as a year of birth or year of marriage. The most common one is the birth cohort, a group of individuals born within a defined time period, usually a calendar year or a five-year interval.

Coinsurance

The percentage of the Private Fee-for-Service Plan charge for services that you may have to pay after you pay any plan deductibles. In a Private Fee-for-Service Plan, the coinsurance payment is a percentage of the cost of the service (like 20%).

Community Mental Health Center

A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharge from inpatient treatment at a mental health facility, 24 hour a day emergency care services, day treatment, other than partial hospitalization services, or psychosocial rehabilitation services, screening for patients considered for admission to State mental health facilities to determine the appropriateness of such admission, and consultation and education services.

Community prevention

Preventive services and interventions that are undertaken on the community rather than individual level. Usually carried out by local public health agencies.

Coordination of Benefits

A program that determines which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare health plan, Federal law may decide who pays first.

Core Public Health Services

The set of public health services that a Colorado local public health agency must either provide, or assure the provision of, pursuant to 6 CCR 1-14-7.

Cost Sharing

The cost for medical care that you pay yourself like a copayment, coinsurance, or deductible.

Cost-Based Health Maintenance Organization

A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

Covered Benefit

A health service or item that is included in your health plan, and that is paid for either partially or fully.

Covered Charges

Services or benefits for which a health plan makes either partial or full payment.

Covered Entity

Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction.

Crosswalking

A new test is determined to be similar to an existing test, multiple existing test codes, or a portion of an existing test code. The new test code is then assigned the related existing local fee schedule amounts and resulting national limitation amount. In some instances, a test may only equate to a portion of a test, and, in those instances, payment at an appropriate percentage of the payment for the existing test is assigned.

Data Use Agreement

Legal binding agreement which CMS requires to obtain identifiable data. It also delineates the confidentiality requirements of the Privacy Act of 1974 security safeguards, and CMS's data use policy and procedures.

Data Use Checklist

A form used to provide pertinent information about the data request and identifies the identifiable data being processed.

Demographic Data

Data that describe the characteristics of enrollee populations within a managed care entity. Demographic data include but are not limited to age, sex, race/ethnicity, and primary language.

Designated Standard

A standard which HHS has designated for use under the authority provided by HIPAA.

Determinants of health

Factors that contribute to a person's current state of health. These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature. Scientists generally recognize five determinants of health of a population:

- Biology and genetics. Examples: sex and age
- Individual behavior. Examples: alcohol use, injection drug use (needles), unprotected sex, and smoking
- Social environment. Examples: discrimination, income, and gender
- Physical environment. Examples: where a person lives and crowding conditions
- Health services. Examples: Access to quality health care and having or not having health insurance ²

Diagnosis Code

The first of these codes is the ICD-9-CM diagnosis code describing the principal diagnosis (i.e. The condition established after study to be chiefly responsible for causing this hospitalization). The remaining codes are the ICD-9-CM diagnosis codes corresponding to additional conditions that coexisted at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay.

Diagnosis-Related Groups

A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.

Disability

For Social Security purposes, the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for a continuous period of not less than 12 months. Special rules apply for workers aged 55 or older whose disability is based on blindness. The law generally requires that a person be disabled continuously for 5 months before he or she can qualify for a disabled worker cash benefit. An additional 24 months is necessary to qualify under Medicare.

² CDC, <http://www.cdc.gov/socialdeterminants/Definitions.html>

Discharge Planning

A process used to decide what a patient needs for a smooth move from one level of care to another. This is done by a social worker or other health care professional. It includes moves from a hospital to a nursing home or to home care. Discharge planning may also include the services of home health agencies to help with the patient's home care.

Disclosure

Release or divulgence of information by an entity to persons or organizations outside of that entity.

Discount Drug List

A list of certain drugs and their proper dosages. The discount drug list includes the drugs the company will discount.

Discretionary Spending

Outlays of funds subject to the Federal appropriations process.

Disenroll

Ending your health care coverage with a health plan.

Disproportionate Share Hospital

A hospital with a disproportionately large share of low-income patients. Under Medicaid, States augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

Drug Tiers

Drug tiers are definable by the plan. The option "tier" was introduced in the PBP to allow plans the ability to group different drug types together (i.e., Generic, Brand, Preferred Brand). In this regard, tiers could be used to describe drug groups that are based on classes of drugs. If the "tier" option is utilized, plans should provide further clarification on the drug type(s) covered under the

tier in the PBP notes section(s). This option was designed to afford users additional flexibility in defining the prescription drug benefit.

Dual Eligible

Persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

Efficient

Activities performed effectively with minimum of waste or unnecessary effort, or producing a high ratio of results to resources.

Eldercare

Public, private, formal, and informal programs and support systems, government laws, and finding ways to meet the needs of the elderly, including: housing, home care, pensions, Social Security, long-term care, health insurance, and elder law.

Electronic Health Record (EHR)

The Electronic Health Record (EHR) is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates and streamlines the clinician's workflow. The EHR has the ability to generate a complete record of a clinical patient encounter - as well as supporting other care-related activities directly or indirectly via interface - including evidence-based decision support, quality management, and outcomes reporting.³

Eligibility

Refers to the process whereby an individual is determined to be eligible for health care coverage through the Medicaid program. Eligibility is determined by the State. Eligibility data are collected and managed by the State or by its Fiscal Agent. In some managed care waiver

³ <http://www.himss.org/library/ehr/>

programs, eligibility records are updated by an Enrollment Broker, who assists the individual in choosing a managed care plan to enroll in.

Emergency Care

Care given for a medical emergency when you believe that your health is in serious danger when every second counts.

Employer Group Health Plan (GHP)

A health plan that gives health coverage to employees, former employees, and their families.

Enroll

To join a health plan.

Enrollment (Medicaid)

Is the process by which a Medicaid eligible person becomes a member of a managed care plan. Enrollment data refer to the managed care plan's information on Medicaid eligible individuals who are plan members. The managed care plan gets its enrollment data from the Medicaid program's eligibility system.

Enrollment Period

A certain period of time when you can join a Medicare health plan if it is open and accepting new Medicare members. If a health plan chooses to be open, it must allow all eligible people with Medicare to join.

Episode of Care

The health care services given during a certain period of time, usually during a hospital stay.

Facility Charge

Some plans may vary cost shares for services based on place of treatment; in effect, charging a cost for the facility in which the service is received.

Federally Qualified Health Center (FQHC)

Health centers that have been approved by the government for a program to give low cost health care. Medicare pays for some health services in FQHCs that are not usually covered, like preventive care. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless.

Fee Schedule A complete listing of fees used by health plans to pay doctors or other providers.

Fee-for-Service

A plan or PCCM is paid for providing services to enrollees solely through fee-for-service payments plus in most cases, a case management fee.

Fiscal Intermediary

A private company that has a contract with Medicare to pay Part A and some Part B bills. (Also called "Intermediary.")

Fraud and Abuse

Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced. Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by Medicare. This is not the same as fraud.

Freedom of Information Act (FOIA)

A law that requires the U.S. Government to give out certain information to the public when it receives a written request. FOIA applies only to records of the Executive Branch of the Federal Government, not to those of the Congress or Federal courts, and does not apply to state governments, local governments, or private groups.

Full Capitation

A plan is paid for providing services to enrollees solely through capitation.

Fully Accredited

Designation that all the elements within all the accreditation standards for which the accreditation organization has been approved by CMS have been surveyed and fully met or have otherwise been determined to be acceptable without significant adverse findings, recommendations, required actions or corrective actions.

General Enrollment Period

The General Enrollment Period is January 1 through March 31 of each year. If you enroll in Premium Part A or Part B during the General Enrollment Period, your coverage starts on July 1.

Generic Drug

A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.

Health Information Exchange (HIE)

The term "health information exchange" (HIE) actually encompasses two related concepts:

Verb: The electronic sharing of health-related information among organizations

Noun: An organization that provides services to enable the electronic sharing of health-related information⁴

Health Insurance Portability & Accountability Act (HIPAA) A law passed in 1996 which is also sometimes called the "Kassebaum-Kennedy" law. This law expands your health care coverage if you have lost your job, or if you move from one job to another, HIPAA protects you and your family if you have: pre-existing medical conditions, and/or problems getting health coverage, and you think it is based on past or present health.

Health Maintenance Organizations (HMO)

⁴ <http://www.healthit.gov/providers-professionals/health-information-exchange>

A type of Medicare managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. You usually must get your care from the providers in the plan.

Health Plan

An entity that assumes the risk of paying for medical treatments, i.e. uninsured patient, self-insured employer, payer, or HMO.

Health Promotion

“The process of enabling people to increase control over their [health](#) and its determinants, and thereby improve their health.”⁵

Home

Location, other than a hospital or other facility, where the patient receives care in a private residence.

Home Health Agency

An organization that gives home care services, like skilled nursing care, physical therapy, occupational therapy, speech therapy, and personal care by home health aides.

Home Health Care

Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Hospice

Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).

⁵ [World Health Organization's \(WHO\) 2005 Bangkok Charter for Health Promotion in a Globalized World.](#)

Hospitalist

A doctor who primarily takes care of patients when they are in the hospital. This doctor will take over your care from your primary doctor when you are in the hospital, keep your primary doctor informed about your progress, and will return you to the care of your primary doctor when you leave the hospital.

Inpatient Care

Health care that you get when you are admitted to a hospital.

Inpatient Hospital

A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by or under the supervision of physicians, to patients admitted for a variety of medical conditions.

Large Group Health Plan

A group health plan that covers employees of either an employer or employee organization that has 100 or more employees.

Letter of Support

A letter from the Federal Project Officer justifying the need for CMS data and supporting the requestor's use of such data.

Licensed

This means a long-term care facility has met certain standards set by a State or local government agency.

Local Public Health Agency (Local Public Health Department)

A county or district public health agency established pursuant to C.R.S. § 25-1-506, or a municipal public health agency established pursuant to C.R.S. §25-1-507. Every Colorado county must maintain a county public health agency, or participate in a district public health

agency. Currently, some counties meet this legal requirement through contracting with another county or non-profit.

Long-Term Care

A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities. Most long-term care is custodial care. Medicare doesn't pay for this type of care if this is the only kind of care you need.

Long-Term Care Insurance

A private insurance policy to help pay for some long-term medical and non-medical care, like help with activities of daily living. Because Medicare generally does not pay for long-term care, this type of insurance policy may help provide coverage for long-term care that you may need in the future. Some long-term care insurance policies offer tax benefits; these are called "Tax-Qualified Policies."

Managed Care

Managed care plans are a type of health insurance. They have contracts with health care providers and medical facilities to provide care for members at reduced costs. These providers make up the plan's network. How much of your care the plan will pay for depends on the network's rules.

Plans that restrict your choices usually cost you less. If you want a flexible plan, it will probably cost more. There are three types of managed care plans:

- Health Maintenance Organizations (HMO) usually only pay for care within the network. You choose a primary care doctor who coordinates most of your care.
- Preferred Provider Organizations (PPO) usually pay more if you get care within the network. They still pay part of the cost if you go outside the network.
- Point of Service (POS) plans let you choose between an HMO or a PPO each time you need care.⁶

⁶ <http://www.nlm.nih.gov/medlineplus/managedcare.html>

Managed Care Organization

Managed Care Organizations are entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. Stands for Managed Care Organization. The term generally includes HMOs, PPOs, and Point of Service plans. In the Medicaid world, other organizations may set up managed care programs to respond to Medicaid managed care. These organizations include Federally Qualified Health Centers, integrated delivery systems, and public health clinics. Is a health maintenance organization, an eligible organization with a contract under 1876 or a Medicare-Choice organization, a provider-sponsored organization, or any other private or public organization, which meets the requirements of 1902 (w) to provide comprehensive services.

Managed Care Plan

In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extra benefits, like extra days in the hospital. In most cases, a type of Medicare Advantage Plan that is available in some areas of the country. Your costs may be lower than in the Original Medicare Plan.

Meaningful Use

In order to achieve meaningful use, eligible providers and hospitals must adopt certified EHR technology and use it to achieve specific objectives. The objectives and criteria for meaningful use are divided into stages. Stage one involves: capturing electronic health data in a standard format, tracking key clinical conditions, utilizing information for care coordination, initiating reports of quality measures and encouraging patient engagement. Stage two involves: electronic transmission of patient care summaries across multiple settings, a more rigorous Health Information Exchange, increased requirements for e-prescribing and incorporating lab results, and increased patient-controlled data. Further stages are still in development. Further information can be found [here](#).⁷

Medicaid

⁷ <http://www.healthit.gov/policy-researchers-implementers/meaningful-use>

A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary

Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.

Medicare

The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD).

Medicare Advantage Plan A

Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease (unless certain exceptions apply). Medicare Advantage Plans used to be called Medicare + Choice Plans.

Medicare Benefits

Health insurance available under Medicare Part A and Part B through the traditional fee-for-service payment system.

Medicare Benefits Notice

A notice you get after your doctor files a claim for Part A services in the Original Medicare Plan. It says what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay. You might also get an Explanation of Medicare Benefits (EOMB) for Part B services or a Medicare Summary Notice (MSN).

Medicare Coverage

Made up of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).

Medicare +Choice

A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage Renal Disease.

Network

A group of doctors, hospitals, pharmacies, and other health care experts hired by a health plan to take care of its members.

Non-Federal Agency

A State or local government agency that receives records contained in a system of records from a Federal agency to be used in a matching program.

Nurse Practitioner

A nurse who has 2 or more years of advanced training and has passed a special exam. A nurse practitioner often works with a doctor and can do some of the same things a doctor does.

Nursing Facility

A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.

Nursing Home

A residence that provides a room, meals, and help with activities of daily living and recreation. Generally, nursing home residents have physical or mental problems that keep them from living on their own. They usually require daily assistance.

Occupational Therapy

Services given to help you return to usual activities (such as bathing, preparing meals, housekeeping) after illness.

Open Enrollment Period

A one-time-only six month period when you can buy any Medigap policy you want that is sold in your State. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you can't be denied coverage or charged more due to past or present health problems.

Outcome Data

Data that measure the health status of people enrolled in managed care resulting from specific medical and health interventions (e.g. the incident of measles among plan enrollees during the calendar year).

Outcome Indicator

An indicator that assesses what happens or does not happen to a patient following a process; agreed upon desired patient characteristics to be achieved; undesired patient conditions to be avoided.

Outpatient Care

Medical or surgical care that does not include an overnight hospital stay.

Part A (Medicare)

Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.

Part B (Medicare)

Medicare medical insurance that helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A.

Partially Capitated

A stipulated dollar amount established for certain health care services while other services are reimbursed on a cost or fee-for-service basis.

Performance Measures

A gauge used to assess the performance of a process or function of any organization.

Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services. Performance measures included here may include measures calculated by the State (from encounter data or another data source), or measures submitted by the MCO/PHP.

Physical Therapy

Treatment of injury and disease by mechanical means, such as heat, light, exercise, and massage.

Physician Assistant (PA)

A person who has 2 or more years of advanced training and has passed a special exam. A physician assistant works with a doctor and can do some of the things a doctor does.

Physician Group

A partnership, association, corporation, individual practice association (IPA), or other group that distributes income from the practice among members. An IPA is considered to be a physician group only if it is composed of individual physicians and has no subcontracts with other physician groups.

Physician Incentive Plan

Any compensation arrangement at any contracting level between an MCO and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicare or Medicaid enrollees in the MCO. MCOs must disclose physician incentive plans between the MCO itself and individual physicians and groups and, also, between groups or intermediate entities (e.g., certain IPAs, Physician-Hospital Organizations) and individual physicians and groups. See 42 C.F.R. 422.208(a).

Plan of Care

Your doctor's written plan saying what kind of services and care you need for your health problem.

Population health

“The health outcomes of a group of individuals, including the distribution of such outcomes within the group.” *Population health* also encompasses the [multiple determinants of health](#) that produce these outcomes.⁸

Population health differs from public health, at least perceptually, in at least two respects. First, it is less directly tied to governmental health departments. Second, it explicitly includes the health care delivery system, which is sometimes seen as separate from or even in opposition to governmental public health.⁹

Population medicine

The specific activities of the medical care system that, by themselves or in collaboration with partners, promote population health beyond the goals of care of the individuals treated.

Population medicine is primarily concerned with clinical or health care determinants of health, but acknowledges the vital role of multi-sector partnerships (such as with public health, education, business, and social services) to influence health more broadly.¹⁰

Preferred Provider Organization (PPO)

A managed care in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Prevention

When measures are taken to prevent conditions rather than treating symptoms once a condition or illness has developed.

⁸ (Kindig, Stoddart, 2003) <http://www.improvingpopulationhealth.org/blog/what-is-population-health.html>

⁹ (Stoto, 2013) <http://www.improvingpopulationhealth.org/blog/what-is-population-health.html>

¹⁰ Harvard Pilgrim Department of Population Medicine

Primary Care

A basic level of care usually given by doctors who work with general and family medicine, internal medicine (internists), pregnant women (obstetricians), and children (pediatricians). A nurse practitioner (NP), a State licensed registered nurse with special training, can also provide this basic level of health care.

Protected Health Information (PHI)

Individually identifiable health information transmitted or maintained in any form or medium, which is held by a covered entity or its business associate. Identifies the individual or offers a reasonable basis for identification. Is created or received by a covered entity or an employer
Relates to a past, present, or future physical or mental condition, provision of health care or payment for health care.

Provider

Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing medical services covered under Medicare Part B. Any organization, institution, or individual that provides health care services to Medicare beneficiaries. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.

Provider Network

The providers with which an M+C Organization contracts or makes arrangements to furnish covered health care services to Medicare enrollees under an M+C coordinated care or network MSA plan.

Public health system

The public health system is distinct from the public health department, in that it includes all the community organizations and agencies that contribute to the “conditions in which people can be

healthy.” It includes all of the public and private resources that contribute to the delivery of public health services.¹¹

Quality Improvement Organization (QIO)

Groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for Service plans, and ambulatory surgical centers.

Risk Adjustment

The way that payments to health plans are changed to take into account a person's health status.

Routine Use

The purposes identifiable data can be collected and the authority to release identifiable data.

Rural Health Clinic

An outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically under-served area that is not urbanized as defined by the U.S. Bureau of Census.

Skilled Nursing Facility (SNF)

A nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.

Social determinants of health

The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal

¹¹ (Scutchfield, 2009)

factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.¹²

Special Enrollment Period

A set time when you can sign up for Medicare Part B if you didn't take Medicare Part B during the Initial Enrollment Period, because you or your spouse were working and had group health plan coverage through the employer or union. You can sign up at anytime you are covered under the group plan based on current employment status. The last eight months of the Special Enrollment Period starts the month after the employment ends or the group health coverage ends, whichever comes first.

Technology Assessment (TA)

Health care TA is a multidisciplinary field of policy analysis. It studies the medical, social, ethical and economic implications of the development, diffusion and use of technologies. In support of NCDs, TA often focuses on the safety and efficacy of technologies. Each NCD includes a comprehensive TA process. For some NCDs, external TAs are requested through the Agency for Health Research and Quality (AHRQ). For a description of the TA process and guiding principles for selecting which topics are refereed for external TA assistance see <http://www.cms.hhs.gov/mcac/guidelines.asp>.

Telemedicine

Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site.

Third Party Administrator (TPA)

An entity required to make or responsible for making payment on behalf of a group health plan.

¹² (Commission on Social Determinants of Health (CSDH), Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. 2008, World Health Organization: Geneva.)

Validation

The process by which the integrity and correctness of data are established. Validation processes can occur immediately after a data item is collected or after a complete set of data is collected.

Valuation Period

A period of years that is considered as a unit for purposes of calculating the status of a trust fund.

Waiting Period

The time between when you sign up with a Medigap insurance company or Medicare health plan and when the coverage starts.

Withhold

Means a percentage of payment or set dollar amounts that are deducted from the payment to the physician group/physician that may or may not be returned depending on specific predetermined factors.

Workers Compensation

Insurance that employers are required to have to cover employees who get sick or injured on the job.

Workforce

Under HIPAA, this means employees, volunteers, trainees, and other persons under the direct control of a covered entity, whether or not they are paid by the covered entity.

Chapter 5 Appendix

Appendix A

Interviewees:

The IT chapter was informed by expert interviews listed below.

Interviews, Committee Meetings, and Collaborate Conversations

Informing SIM Health IT Chapter

Roger Gunter	•Chief Executive Officer, Behavioral Health Inc.
Julie Holtz	•Colorado Access Region 5
Dave Rastatter	•Colorado Access Region 2
Mark Wallace	•Chief Executive Officer, Northern Colorado Health Alliance
Sharon Raggio	•Chief Executive Officer, Colorado West
Shelly Burke	•Chief Executive Officer, Axis
Kelly Joines	•Interim Chief Executive Office, CORHIO
Brian Braun	•Chief Financial Officer, CORHIO
Jeff Messer	•Director of Strategy, CORHIO
Mark Carlson	•Sr. Manager, Outreach and Business Development, CORHIO
Drew Currie	•Manager, Outreach and Business Development, CORHIO
Scott Wallace	•Manager, Outreach and Business Development, CORHIO
Joel Dalzell	•Section Manager, Health Data Strategy Health Care Policy and Finance
Chris Wells	•Director of Architecture, Governor’s Office of Information Technology, and interim State HIT Coordinator
Dianna Anderson	•Chief Data Officer, Governor’s Office of Information Technology
John Mahilik	•Program Director, Data Integration Initiative, Office of Behavioral Health
Troy Evans	•Project Manager, Data Integration Initiative, Office of Behavioral Health
Dr. Ben Miller	•University of Colorado State Innovation Model Team

Barbara Martin

Mary Brown

- Director of External Affairs, Quality Health Network

**Ed Bostwick and
CTN team**

- CEO, Colorado Telehealth Network

Charlie Hewitt

- HIE Director of Product Delivery, Rhode Island Quality Institute

Laura Widder

- Implementation Project Manager Supervisor, Wisconsin State Health Information Exchange

**PH HIE Steering
Committee**

(2 meetings)

- 35 CDPHE and local public health agency SMEs

**Behavioral Health
Information**

Exchange

Committee

(2 meetings)

- Colorado Association of Alcohol and Drug Service Providers
(a.k.a.) the Colorado Providers Association
- Colorado Behavioral Healthcare Council
- Colorado Department of Human Services, Division of Behavioral Health
- Colorado Mental Wellness Network
- Community Reach Center
- Federation of Families for Children’s Mental Health – Colorado Chapter
- Mental Health America of Colorado
- National Alliance on Mental Illness – Colorado Chapter
- Quality Health Network

**SIM Public Health
workgroup**

- SIM public health workgroup stakeholders

**SIM Stakeholder
meeting**

- State Innovation Model stakeholders
-

History of Health IT in Colorado

Colorado has been a leading state in developing a vision for statewide Health Information Technology (HIT) since at least 2004, when stakeholders came together to advocate for and develop the current statewide, collaborative governance model, health information organizations

and initial prototypes for statewide interoperability. Through state legislation, blue ribbon commissions, federal awards and Executive Orders, Colorado committed to developing a statewide strategy for advancing HIT to improve the health of Coloradoans.

State Executive orders advancing health information technology in Colorado:

- Created in 2007 through Senate Bill 07-196, the Health Information Technology Advisory Committee was charged with creating a comprehensive, long-term plan for HIT in the State. “to develop a long range plan for health care information technology, including the use of electronic medical records, computerized clinical support systems, computerized physician order entry, regional data sharing interchanges for health care information, data privacy and security measures, and other methods of incorporating information technology in pursuit of greater cost-effectiveness and better patient outcomes in healthcare.” – Senate bill 196
- Through Executive Order in 2009, Colorado Regional Health Information Organization (CORHIO) was granted status as the State-Designated Entity (SDE) for health information exchange (HIE) and has since developed significant capacity to support the electronic exchange of clinical health information across Colorado communities.
- Created in 2008 the Colorado Telehealth Network (CTN) to provide dedicated, statewide health care broadband infrastructure. CTN serves 100 behavioral plus 100 physical health care sites, the majority of which are rural, in a single, unified network.

As Colorado navigated early HIT initiatives, passage of the federal legislation Health Information Technology for Economic and Clinical Health Act (HITECH), part of the American Recovery and Reinvestment Act (ARRA), strengthened Colorado’s health strategy by enabling a series of priority programs for states to advance the use of health information technology and exchange health information. HITECH ARRA’s passage in 2009 included incentives designed to advance the planning for appropriate use of HIT, by improving the use of tools and innovations to improve quality, efficiency and safety of health care. Colorado leveraged HITECH programs to implement a sustainable infrastructure advocating data capture, standards, and exchange of health information contributing to health care reform. Examples of HITECH programs include loans, grants, technical assistance, IT related workforce training programs, and research and development projects. A list of Colorado HITECH funded programs advancing

adoption of HIT and interoperability through health information exchange (HIE) are listed below.

- BEACON Community award to Rocky Mountain Health Plans and an association of Mesa County health care organizations
- Community College Consortium award to a partnership of community colleges including Pueblo Community College
- University-based Training award to the University of Colorado Denver School of Nursing
- Regional Extension Center (CO-REC) awarded to CORHIO
- State HIE Cooperative Agreement Grant awarded to CORHIO
- Long-term Post-acute Care Transitions Challenge Grant awarded to CORHIO

Colorado supplements HITECH funded programs with other ARRA funds, such as broadband funding helping the state’s connectivity challenges. Colorado also utilizes regional partnerships with health care organizations, such as The Colorado Health Foundation, to enhance the infrastructure needed to support HIT efforts.

Colorado's health care safety net consists of those providers offering medical, dental and mental health care to low-income, uninsured and underinsured individuals and people enrolled in publicly-funded health insurance programs. Safety net providers include: emergency departments of community and public hospitals, community health centers (also known as Federally Qualified Health Centers (FQHCs), local public health departments and public nursing services, community-funded clinics, federally-designated rural health clinics, school-based health centers, community mental health centers, and community-based low-income dental clinics. (Source: Colorado Health Institute, Colorado Health Care Safety Net Primer, August 2011.)

HITECH Program	HITECH Program Role	Grantee Name	Total Funding
Beacon Communities Program	Recipient	Colorado Beacon Community	\$11,878,279

Community College Consortia to Educate Health IT Professionals	Consortia Member	Pueblo Community College	\$0
Health Information Technology Extension Program Regional Extension Center Cooperative Agreement Program	Recipient	Colorado RHIO	\$13,563,775
Program of Assistance for University-Based Training	Recipient	University of Colorado Denver College of Nursing	\$2,622,186
State Health Information Exchange	Recipient	Colorado Regional Health Information Organization	\$10,894,560

CORHIO overview

Colorado Regional Extension Center

CORHIO operates the Colorado Regional Extension Center, which offers technical assistance, guidance and information on best practices to support and accelerate Colorado health care providers' efforts to become meaningful users of Electronic Health Records (EHRs). The Colorado Regional Extension Center directly helps qualified primary health care providers implement and meaningfully use EHRs and HIE.

CORHIO works closely with communities across Colorado to develop and implement HIE. This ensures HIE meets each community's unique health care goals. Within communities, CORHIO collaborates with all health care stakeholders. With broad community participation, together we can make dramatic improvements to health care quality and population health, while simultaneously reducing costs.

Health Care Providers Served by CORHIO HIE:

- Physicians
- Mid-level Practitioners (Physician Assistants, Nurse Practitioners, Certified Nurse Midwives)
- Doctors of Dentistry, Optometry and Podiatry
- Hospitals
- Safety Net Clinics

- Behavioral & Mental Health Providers
- County/State Departments of Public Health
- Long-term Care
- Home Health
- Hospice
- Labs
- Imaging Centers
- Urgent Care Clinics

Current HIE capabilities

The technical model provides for a secure confederated architecture for CORHIO, which allows each participating organization to maintain its own clinical data store in an edge server, allowing custodianship of its own data and security policies for all data it contributes. The HIE can aggregate patient information from disparate systems into a single view of a patient record, while simultaneously providing an infrastructure that allows contributing organizations to maintain and control their own data without co-mingling that data with other participants.

CORHIO currently exchanges the following information and has plans to develop capabilities to exchange additional data advancing HIE in Colorado.

HIE capability	Current	Planned
Provider authentication as shared service	X	
Patient Matching (Master Patient Index) as shared service	X	
Authoritative, statewide provider directory as shared service	X	
Quality Reporting as shared service		X
Prescription fill status and/or medication fill history as shared service		X
Submission of reportable lab results as shared service	X	
Public health agency(ies) capability to accept electronic submission of reportable lab results as shared service	X	
Electronic reporting of immunizations as shared service	X	
Electronic clinical laboratory ordering as shared service		X
Secure messaging as shared service	X	
Directed messaging as shared service	X	

Clinical summary record exchange as shared service	X	
Electronic laboratory results delivery as shared service	X	
ePrescribing as shared service	X	
Consent Management as shared service	X	
Health Information Service Provider as shared service	X	

Standardized solutions for moving health information through the CORHIO HIE include:

- An architecture that allows the use of the NHIN gateway to exchange data between CORHIO and QHN (HIE to HIE), as well as with state and federal organizations such as Medicaid, VA, Department of Corrections, etc.
- Integration of NHIN Direct connectivity methods for the improved coordination of care
- Support of all HIPAA-standard transaction sets including HL7 and ANSI
- Support of message sets that are used with a wide variety of commercially available hospital, reference lab, payer, practice management, and EHR products
- Support of HIE interoperability services standards
- Integration of supported standards for terminology services: LOINC, CPT4, HCPCS, ICD-9, ICD-10, SNOMED CT, RxNorm, NCD, MULTUM, MicroMedex, Medispan, UMLS, UCUM, and UNII

Hospitals Participating in HIE

- Animas Surgical Hospital
- Avista Adventist Hospital
- **Boulder Community Hospital**
- **Boulder Community Foothills Hospital**
- **Castle Rock Adventist Hospital**
- **Children's Hospital Colorado**
- **Craig Hospital**
- Denver Health & Hospital Authority
- **East Morgan County Hospital**
- Good Samaritan Medical Center
- **Littleton Adventist Hospital**
- **Longmont United Hospital**
- Lutheran Medical Center
- **McKee Medical Center**
- The Medical Center of Aurora
- **Medical Center of the Rockies**
- **Mercy Regional Medical Center**
- **Memorial Hospital Central**
- **Memorial Hospital for Children**
- **Memorial Hospital North**

- **Northern Colorado Medical Center**
- North Suburban Medical Center
- **OrthoColorado Hospital**
- Pagosa Springs Medical Center
- **Parker Adventist Hospital**
- **Parkview Medical Center**
- **Penrose Hospital**
- **Porter Adventist Hospital**
- **Poudre Valley Hospital**
- Presbyterian/St. Luke's Medical Center & the Rocky Mountain Hospital for Children
- Rose Medical Center
- Saint Joseph Hospital
- Sky Ridge Medical Center
- Southwest Memorial Hospital
- Spalding Rehabilitation Hospital
- Swedish Medical Center
- **St. Anthony Hospital**
- **St. Anthony North Hospital**
- **St. Anthony Summit Medical Center**
- **St. Francis Medical Center**
- **St. Mary-Corwin Hospital**
- **St. Thomas More Hospital**
- **San Luis Valley Regional Medical Center**
- **Sterling Regional MedCenter**
- **University of Colorado Hospital (UCHealth)**
- **Bold = Connected to HIE (Live)**
- Non-bold = Under agreement, in implementation

CORHIO Behavioral Health History

CORHIO has actively engaged local Community Mental Health Centers throughout the state to advocate additional participation. This includes the development of a tiered pricing structure, waiving implementation fees for EHR Integrations. As a result of these efforts, SyCare, a leading provider of mental health services in the state, has two facilities- San Luis Valley Mental Health Center and Spanish Peaks Behavioral Health Center - now accessing lab results through CORHIO. This enables the facilities to provide enhanced care coordination for patients through HIE connectivity. The facilities are the first two behavioral health facilities in the state to join CORHIO's secure network. As of September 2013, 17 mental health centers are live with CORHIO with an additional two centers in development.

Consent Models

This functionality is currently in development, and will eventually support flagging data by person, diagnosis, or other encounter level data. Restricting or granting user access to view confidential data via CORHIO will be controlled through organizational-level settings. An administrator will be able to restrict or grant rights to view confidential data to a group of users through this administrative tool. Access to this will follow the existing data access model, so users can be given normal access rights to view confidential data or can be given access additional records rights to break glass and view confidential data as needed. In the longer-term, this tool can be used to restrict or grant access to their confidential data through enhanced consent functionality. Through this tool, an administrator could change a patient's confidential data consent status to opt-in or opt-out for all users or for users associated with selected organizations. Therefore, if a confidential data opt-out is selected for a patient, all information flagged with an HL7 confidential indicator for that patient will not be available for viewing through CORHIO. The confidential data opt-out setting will override a user's rights to access confidential data. The confidential data consent setting is patient specific, so a user could see confidential data for one patient, but be restricted from seeing it for another patient.¹³ The following information, provided by Medicity, explains the available options for selecting a patient's consent status:

- Opt-in: Allows all users with appropriate access rights to view the patient's record without any data or organizational limitations (Currently available)
- Opt-out: Restricts all users from accessing the patient's record (Currently available)
- Limited: Limits access to the patient's record to just those users who are associated with pre-authorized organizations given access to confidential data (In development)

¹³ Csakai, Caitlyn. "Behavioral Health Information Exchange" December 2012.

Detailed Consent Model

Informed Consent for Sensitive Health Information: Patient would have to “opt-in” or sign specific consent to share sensitive information in the HIE. Sensitive information can include mental health and substance use treatment information, as well as physical health diagnoses such as sexually transmitted diseases. This could also help navigate the 42 CFR Part 2 requirements. Some barriers will exist, as separating information considered particularly sensitive from the rest of a patient health record could create significant gaps in patient health information for treating providers. Having specific consent for sensitive information could also create a substantial administrative burden for providers required to manage and track consent. Electronic consent forms are being developed at the national level, and could be utilized in the long term.

Tiered Consent by Provider Type: Sensitive health information, including behavioral health information could be segregated by provider. For example, specifically flagged data elements (i.e. sensitive health information) would only be made available to specific provider types (i.e. ER doctor, primary care physician) and would be limited to other types of providers (i.e. specialists). This type of model could also orchestrate sharing behavioral health information only among behavioral health providers. Detailed policies would have to be developed and significant time and input would be needed to determine what type of data should be segmented, and what providers should have access to each type. This would also require a technical build for both providers and CORHIO to appropriately flag data. This scenario creates potential information gaps for treating providers, but helps maintain a trust environment for consumers.

“Facebook Model” or Patient- Monitored Information Sharing: Patients actively select who has access to what information at a very granular level, giving the patient the ultimate control over information. A great deal of technical work would be needed to make this feasible. There would be a need to create a personal health record for all patients in the state. At this time, patients do not interact directly with the HIE. Although this could empower patients, it shifts responsibility to them. This model also creates the most significant gaps in information, which may have negative treatment consequences by leaving out important pieces of information regarding a patient’s medications or conditions.

Current Behavioral Health Information Exchange Strategy

Phase 1: Consent Model

- Identify sustainable consent model for exchanging mental health, substance abuse, and sensitive information across the organizations and statewide HIE

- Update policies to support expanded health information sharing

Phase 2: Technical Solution

- Identify technical solution to support consent model with data segmentation, identification of consents, filtering for consented providers, or quarantine of sensitive information.
- Approach may be iterative with the use of mini-HIEs sharing data across EHRs within organizations, across organizations but not publishing to HIE, then full sharing across organizations and publishing in the HIE

Phase 3: Operational Support

- Create operational processes to align consents, audits, and compliance for consent management.
- First phases may support manual consents, but the ideal "to be" would be consent captured within the EHR and sent via discreet message to HIE for provider filtering and segmented data

Phase 4: Sensitive HIE

- Begin mental health, substance abuse, and sensitive information sharing with pilot programs,
- Then advance with small set of early adopters to create community of trust
- TO be - long-term sensitive information sharing securely across organizations and published to HIE promoting integrated care

Phase 5: Sensitive Info to PHR

- Once the technical platform can support sensitive information exchange, the next step is to include this information with portals and personal health records
- To be- patients would administer their own consents via PHRs or portals, publishing the consents to health providers and HIE for transparency and availability of consents.

Other State research –

- CORHIO and Rhode Island Quality Institute had a knowledge sharing call to discuss Rhode Island's successful project sharing Substance Abuse information within the State HIE.

Recommendations from the session included:

- State created and required consent form capturing written consent giving permission to release sensitive information and share all, some, or no health information with the State HIE.
- State required participation with the State HIE as a part of the Medicaid audit requirements.

- Create “quarantine” capability in the HIE to keep sensitive information separate but still accessible in the HIE. The quarantine allows the capability to disable sharing of the sensitive information without preventing all health information from being shared.
- Wisconsin Health Information Network consent model

Privacy Policies impacting HIE

- HIPAA Privacy Rule
- HIPAA Security Rule
- HITECH Subtitle D – Privacy
- Colorado Revised Statutes:
 - CRS 6-1-716 Data Breach Notification
 - CRS 10-3-1104.7 Limits on Disclosing Genetic Information
 - CRS 10-16-1003 Privacy of Health Information 48
 - CRS 18-4-412 Theft of Medical Records or Medical Information
 - CRS 25-1-122 Named Reporting of Certain Diseases and Conditions - Access to Medical Records - Confidentiality of Reports and Records
 - CRS 25-1-122.5 Confidentiality of Genetic Testing Records - "Uniform Parentage Act"
 - CRS 25-4-1404 Reporting Sexually Transmitted Infections
 - CCHIT 09 HIE Self-Attestation Guidance, for Certification of HIEs, Version 09.01, September 29, 2008
- State of Colorado Data Strategy for Privacy and Security—HB 08-0364 and 09-1285,
- Electronic HealthCare Network Accreditation Commission (EHNAC) publishes a set of Accreditation criteria for health information exchange (HIE) programs and provides certification services. These criteria are currently in a draft state, with release targeted for April 1, 2010.
- While EHNAC has not been designated by HHS as a certifying body, many of the criteria provide cross-references to pertinent HIPAA rules (45 CFR parts 160, 162, 164)
- National Institute of Standards and Technologies (NIST) Special Publication 800-53, Recommended Security Controls for Federal Information Systems and Organizations¹⁴
- DURSA

Quality Health Network (QHN)

¹⁴ CORHIO Strategy Document

The initial focus was on diabetes, cardiovascular disease, mammograms, depression screening and preventive health screenings. This data allows physicians to identify and prevent gaps in care.

To support the organization's vision to improve care, QHN also began a focused effort to connect all allied healthcare entities within each of the local communities to the HIE infrastructure in order to improve care transitions and care coordination – including not only hospitals and physicians but also home health, hospice, extended care, behavioral health, urgent care, surgical centers, durable medical equipment, physical therapy, public health, case managers, etc. These connected groups of provider organizations within communities, often defined by geography, have become known as “medical neighborhoods” and reflected area referral patterns of care within the “neighborhood of care”. QHN's objective is to maximize connectivity within each neighborhood and unite providers behind a common virtual health record to move data, including referrals and progress notes, electronically.

QHN is also working with the 12 western Colorado practices that are part of Colorado's Comprehensive Primary Care initiative (CPCi). This multi-payer collaboration, which includes private payers, Medicaid and Medicare, is focused on strengthening primary care through enhanced care coordination. The integration of population health management tools is fundamental to this clinical transformation initiative, with a focus on the assimilation of behavioral health and primary care in the care setting to help care providers predict needs, prioritize resources and engage patients in preventative care. QHN's HIE is an integral part of this clinical transformation providing data and performance measurement tools across multiple payers as well as providing primary physicians with real time “alerts” when their patients are admitted to emergency or acute care settings.

QHN Privacy policy

QHN has strict access policies to protect patient information within the Virtual Health Record. Only licensed health care professionals responsible for clinical patient care and members of their care team directly involved in patient care are allowed access. This access allows credentialed users to query the patient to find all clinical information on a patient from all disparate sources.

QHN has a very aggressive privacy, security and audit policies aligned with all federal and state privacy and security laws and regulations and requires all participating users to submit their organizational audit policy prior to access permission being granted. All access of patient records is monitored and any breach of access is immediately investigated and corrective action is taken.

The QHN has an established “Opt- out” policy, which prevents their health information from being queried, even in the case of an emergency. Diagnostic testing results are still exchanged between the organization performing the testing and the provider.

Other HIE efforts in Colorado

Other Health Information Exchange Initiatives in Colorado

- Physician Network, which provide more limited functionality to a subset of Medical Referral Region providers. The Northern Colorado Health Alliance is comprised of three safety net providers in Weld County including the Weld County Public Health Department, Sunrise Community Health Center (a federally qualified health center) and North Range Behavioral Health Center. These three organizations share a community health record to serve their common patients.
- The Children’s Hospital has also implemented a community electronic health record called PedsConnect to over ten community practice provider locations across Colorado, as well as offered CareEverywhere, an Epic-to-Epic HIE between Children’s, Kaiser Permanente Colorado, and Exempla Healthcare.
- CareEverywhere, an Epic-to-Epic HIE between Children’s, Kaiser Permanente Colorado, and Exempla Healthcare
- Functional since 2006, the Avista Integrated Physician Network (Avista iPN) is a physician-driven initiative supported initially through a grant from the Health Resources and Services Administration (HRSA) and the commitment of area health care providers to better serve the underserved in the Boulder area. By creating a complete longitudinal patient record, Avista iPN allows participating providers to immediately access and share patient data across EHR systems in the local FQHC, local hospitals, and many private physician practices. Colorado Access – a Medicare, Medicaid, and CHP+ HMO – and the local public health department are also integrally involved.
- CACHIE, an initiative of the Colorado Community Managed Care Network, is building a data warehouse to manage and monitor quality performance for FQHCs and other safety net clinics. Funded through the ARRA Health Center Integrated Services Development Initiative at HRSA, CACHIE is building the technology and infrastructure for Colorado’s FQHCs to:
- Health TeamWorks and Colorado Associated Community Health Information Exchange (CACHIE) are both statewide quality initiatives that benefit from an HIE to facilitate quality improvement in clinical care. Health TeamWorks provides a disease registry, patient portal and clinical messaging system to 88 practices and 1,000+ users.

Impact of Broadband Access on Provider Adoption of HIT and HIE

As stated in the original State Medicaid Health Information Technology Plan (SHMP), the lack of broadband access in Colorado's rural and mountainous areas presents a particular challenge for HIT adoption and HIE. Because of Colorado's mountainous terrain, construction of wireless and terrestrial facilities to facilitate high-speed internet connectivity can be economically infeasible. However, the Governor's Office of Information Technology is working intensely to analyze gaps in service and deploy broadband and other telecommunications services to health care providers throughout the state, in support of HIT and other uses. The Colorado Telehealth Network and the Colorado Behavioral Healthcare Council are leveraging significant grant funding from the Federal Communications Commission to deploy broadband connectivity to hospitals and behavioral health providers for purposes of telemedicine and improved communication. The Colorado Broadband Data and Development Program within the Governor's Office of Information Technology is mapping statewide broadband availability and prioritizing connections between county seats of government and other local institutions.

Additionally, Colorado has received ARRA broadband funding to help meet some of the state's last-mile connectivity challenges. EAGLE Net (Educational Access Gateway Learning Environment Network) was awarded over \$100 million in ARRA funds to bring broadband service to school districts, libraries, and community anchor institutions across Colorado. The Nunn Telephone Company in north central Colorado is utilizing ARRA funding to bring broadband access to the 200 businesses and 1,000 residents it serves. The Peetz Co-operative Telephone Company is now deploying broadband infrastructure in the northeastern corner of the state, connecting anchor institutions within the remote, underserved farming community along the Wyoming border to necessary distance learning and public safety applications. In addition, the Wiggins Telephone Association was also awarded broadband funding to construct fiber-to-the-premise networks in the rural areas of northeastern Colorado.¹⁵

State Health IT initiatives:

Office of Behavioral Health (OBH)

At a state level, providers are implementing integrated behavioral health care services which require separate data entry to CCAR and DACODS for each behavioral health client by mandate of DBH. These efforts are time consuming and costly to behavioral health providers and result in less efficient, effective and elegant care for their clients. The DACODS and CCAR often answer the same questions but with slightly different wording and different selections of responses. As a result, behavioral health care

¹⁵ State Medicaid Health Information Technology Plan, 2012.

providers fill out the same clinical information twice - causing more operational expense and taking more clinical time away from clients. Currently, providers across the state complete over 200,000 DACODS and CCAR forms annually. This results in 50,000 hours of data entry costs.¹⁶

Opportunity -Integrating behavioral health into the larger physical health system has become a great challenge but an even greater opportunity. In order to meet this challenge, behavioral health providers must utilize a data tool that can communicate properly with other health care providers and report on federally mandated “meaningful use” measures to ensure clientele’s physical and behavioral health needs are being addressed concurrently in reflection of clinical reality.

Based on health services research studies on co-occurring rates among behavioral health clients (indicating the number of clients needing both DACODS and CCAR assessments), an integrated data collection tool would reduce the data entry cost by as much as 40%.

With an integrated data collection tool, the DBH and the Department will be able to measure the following for the first time:

- Appropriateness and completeness of treatment and prevention services for co-occurring behavioral health clients.
- Improved health care services and outcomes for our clients seeking integrated behavioral and physical health services (e.g., smoking cessation and/or weight control).
- Improved client penetration rates in Colorado’s communities (i.e., urban, rural and frontier) by becoming a more integral part of the physical health care system.
- Increased client engagement and retention rates as behavioral health clients integrate behavioral and physical health as part of their overall wellness recovery plans.
- Increased ability to track clients over time to evaluate the process and outcomes of implementing behavioral health evidence-based and promising practices in relation to bridging the quality chasm (i.e., science-to-practice gap) and addressing federal reporting requirements in the context of health care reform.

Medicaid data – RCCOs/BHOs

Medicaid Management Information System

¹⁶ Mahilik, John and Troy Evatt. “Office of Behavioral Health Data Integration Strategy overview” July 2013.

RCCOs are at various stages of health IT adoption with differing solutions for physical and behavioral health EHR needs. Rocky Mountain Health Plan has had a long history of interoperability with QHN and has made information exchange a strategic priority for better health care and reduced costs. Colorado Access is in development with CORHIO to receive lab results, ADT feeds, and eligibility based routing information.

Data needs (HCPF/RCCOs/BHOs) – The Department is planning efforts to aggregate clinical and administrative data to improve reports and reporting time frames for payers, providers, patients, and policy recommendations.

Limited BH data - BHOs/RCCOs have risk stratification strategies in place utilizing claims information, which may be delayed or incomplete. The claims data does not include clinical data and this may be a gap in analytics capabilities across the state. RCCOs and BHOs have been tasked with doing an assessment analyzing what data do they have, need, that crosses behavioral health boundaries looking towards the SDAC to facilitate data sharing. The current reality is the SDAC is dependent on the MMIS. Data for BH is limited and incomplete b/c BHOs technical issues to submit data to MMIS. There is a current workgroup to submit BH data to MMIS (two year plan). If it were to be fixed and MMIS had more BH info, then flow through to the SDAC. SDAC only provides is physical health info, BH can't get access to SDAC b/c not part of ACC program. At that time SDAC was thought to be best mechanism to providers, but this may not be true for provider level data and analytics. Providers are much more engaged with EHRs, haven't been involved in EHRs, opportunity for HIE from MMIS or where and through HIE better long term solution.

Privacy policy and consent models – Privacy policies and consent models create barriers for THE DEPARTMENT and at the organizational level, operational level. A state level consent model and form could facilitate the consent barriers among substance abuse 42 CFR Part 2, Colorado statutes.

Mental health data sharing – There is no line of site who is receiving services with BH , with Medicaid benefit pay BHO then BHO submit encounter data, capitated. Organizations/BHOs are supposed to submit information, but this isn't consistent. Current systems don't accept data well. Policy up until this point is to only share info on the physical on BH side, if client is utilizing services. Everyone is enrolled into BHO automatically, but patients may not receiving services.

Current MMIS efforts

The Department completed an assessment in 2012 of the current Medicaid Management Information System (MMIS) and is developing a strategy for modernization and re-procurement of the entire system within the next five years. This strategy will incorporate the implementation of federal and state legislation within the current MMIS and provide guidance for the development of a Request for Proposals (RFP) for its re-procurement by July 2015. Until the re-procurement strategy is finalized and implemented, the Department is continuing to utilize the current MMIS under a 5-year extension to the fiscal agent contract with Affiliated Computer Services (ACS).

In two cases, Healthcare Information Technology for Economic and Clinical Health (HITECH) and the Accountable Care Collaborative (ACC), the Department is utilizing external vendors to create systems and perform work to implement legislative requirements. This approach will minimize or reduce the impact on the Department and the MMIS. HITECH implementation will have a minimal impact on the MMIS because the State of Colorado has designated CORHIO as the lead entity for HIE and the Department is planning to hire an Attestation Vendor to handle eligibility, enrollment, and payment in the Medicaid EHR Incentive Program and audit the providers and hospitals over the 10 year life of the program. This will require an interface between the attestation system and the current and future MMIS will be necessary in order to make the actual incentive payments, which minimizes the direct impact to the MMIS.

Many interfaces that exchange data between the MMIS and other State information systems are required in order for the Department to implement these initiatives. Some of these interfaces already exist and will have to be modified; others will have to be created between the MMIS and newly developed systems. The list below identifies these interfaces:

- Attestation Vendor to MMIS - HITECH
- Colorado Benefit Management System (CBMS) to MMIS - Children's Health Insurance Program Reauthorization Act (CHIPRA)
- Social Security Administration's (SSA) State Verification and Exchange System (SAVE) to CBMS - CHIPRA
- MMIS to Statewide Data and Analytics Contractor (SDAC) system - ACC
- MMIS to Colorado Financial Reporting System (COFRS) - HITECH and ACC
- MMIS to Provider Enrollment System – CMS Provider Application Requirements Final Rule

The Patient Protection and Affordable Care Act (PPACA) will increase the number of Coloradans that are eligible for Medicaid assistance. Additionally, the legislation promotes administrative simplification of

the enrollment process and form, promotes increased communication regarding available benefits, and promotes solutions to improve access to care and quality of care. The legislative changes will increase transaction and data volumes and the Department will have to plan accordingly for these increased volumes across various platforms and systems. As with the other initiatives, changes made to the current MMIS to comply with this legislation will be documented and tracked, as they may result in requirements for the future MMIS. Many of these initiatives, both federal and state, will fundamentally affect the way in which the Department does business, not just the MMIS or other information systems.

Other references for Colorado Health IT initiatives include the following:

- State Medicaid Health Information Technology Plan version 2012 – currently being updated with current information on health IT projects
- Colorado Health IT Advisory Committee Report and Recommendations April 2009
- CORHIO Strategy 2009

Detailed Functionality Recommendations

Data Capture - advance EHR capabilities to adequately capture physical and mental health information in one EHR meeting data standards, privacy controls, and enable treatment of the whole person within one EHR system.

- Questionnaires available for data capture physical and mental health information configurable to add more assessments as supported by best practices
- Data entry fields supporting industry standards for quality measures, MU reporting, C-CDA, data segmentation, transport to statewide HIE, and reporting to public health for population management
- Patient level consent fields for data integration beyond the practice

Security based configuration for sensitive notes, diagnoses, or other information

- User role based security for appropriate level of access by all levels of the care teams,
- Documentation for sensitive notes that may be segmented when shared or viewed only by consented providers
- Documentation of consent readily accessible to treating care team internally and externally, if referred for specialty care
- Problem list with capability to identify sensitive diagnoses viewable by only appropriate levels of care team or consented providers internally or externally

Analytics

- Reports measuring questionnaire responses over time cross referenced with medication changes, behavior modifications, updates to treatment plans, or other significant events
- Internal registries of conditions with facility, care team, and provider level dashboards for displaying coexisting conditions overtime (e.g., diabetics with depression diagnosis by medication prescriptions or treatment plans)
- Dashboards available in an encounter for discussion with patients to show improvements over time

Promote adoption of health information technology tools - Promote adoption of EHRs robust enough to allow configurable user role security setting protecting patient's sensitive information. An example of this would be Medical Assistant's ability to view only the physical health encounter information, a

Registered Nurse role with the ability to see mental health consultation took place within the primary care encounter, and the mid-level, MD, and mental health provider is able to see all of the encounter's details include sensitive notes and physical health notes.

- Advocate for mental health screening tools are configured and available for data capture within all clinical visits, telephone, patient reported, and in-person events.
- Discourage use of disparate EHRs for capturing mental health encounters and information.
- Support continuing education on EHR tools, questionnaires, dashboards, and reports to continue adoption and improved use of health IT tools.
- behavioral health electronic medical records (BH EMRs) and improved BH data capture standards in ambulatory EMRs
- Coordinate the adoption and use of health IT to support broader objectives of integrating behavioral health and primary care
- Develop and communicate mechanisms for bidirectional communications with primary care providers;
 - a determination of what information is most essential to share;
 - and adoption of appropriate confidentiality and consent protocols.ⁱ
- Health information technology can enhance evidence based guidelines, such as SBIRT service delivery, by promoting consistent workflow and best practices
 - Support and develop a plan for the protected exchange of behavioral health information among authorized providers
- Use of telehealth technologies to serve rural and small communities
- Capturing mental health and substance use treatment information in a streamlined manner and linking to Medicaid systems to provide actionable health information to Medicaid providers, benefits management services, and program administrators to reduce administrative burden and improve effectiveness
- Funding for Health IT tools, including but not limited to HIE and telehealth in small, rural communities.

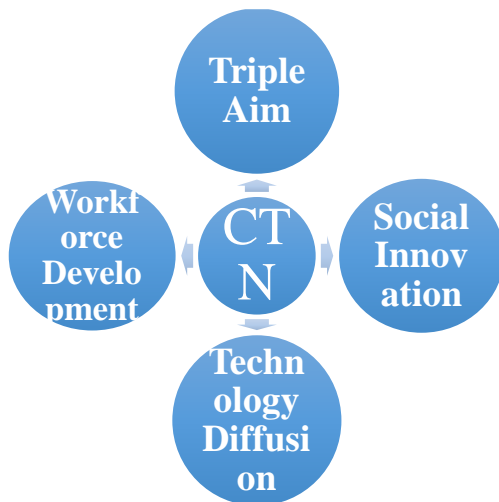
The Colorado Telehealth Network (CTN) was formed in 2008 by the Colorado Hospital Association (CHA) and the Colorado Behavioral Health Council (CBHC) to improve patient care and safety by providing the core network infrastructure that would:

- Enable rural health care organizations to increase their use of health information technology, such as Electronic Medical Records; and
- Encourage health care organizations to collaborate and integrate in ways not possible without a high-capacity, connected network.

To further its mission, CTN has proposed a 5-point plan to advance rapid diffusion of telehealth access throughout both rural and metropolitan Colorado.



CTN advances policy goals and health outcomes to rural and underserved communities by focusing on four specific areas.



- CTN can assist in the implementation of the Affordable Care Act to help reduce Medicaid cost by utilizing its broadband network to offer video telehealth access to rural and underserved communities across Colorado. Currently, CTN has 195 Colorado hospitals, clinics and behavioral health care centers (rural and urban) connected to the CTN broadband network. Future plans are to onboard another 200+ Colorado hospitals, clinics, and behavioral health care centers.

- CTN can assist in supporting the Governor’s Behavioral Health Agenda, including expansion of crisis centers, improved community mental health, and increased capacity in the mental health system. All of the Colorado Behavioral Health Centers are connect to CTN. These Behavioral Health Centers partner to form the five current Colorado Behavioral Health Organizations (BHOs). This current connection can be expanded to include video telehealth access to address current and future needs.
- CTN can provide statewide connection and video telehealth access to support the Regional Care Collaborative Organizations (RCCOs) with connecting Medicaid clients to Medicaid Primary Care Medical Providers (PCMPs). CTN can assist THE DEPARTMENT in developing models that connect Colorado based specialty providers to the Accountable Care Collaboration (ACC), reducing the burden of patient reliance on out-of-state specialists and telehealth networks.
- CTN can provide a statewide connections and video telehealth access to support various telepharmacy programs that support SAMHSAs prevention and early intervention initiatives aimed at reduction of prescription drug misuse and abuse.
- CTN can utilize its broadband network and telehealth access to partner with other Colorado health organizations, such as CORHIO, QHN, CHI, and CIVHC. CTN can also partner with out-of-state telehealth organizations, such as Project ECHO in New Mexico. Joint collaborations can provide additional coverage and benefits to Colorado residents and underserved residents of states in the Rocky Mountain region.
- CTN can provide statewide connection and video telehealth access to address cost reduction in healthcare training, health professional certification/ accreditation, and continuing education (CME). The use of such a network will reduce travel costs and provide a platform for online content that does not require hard copy print materials.

As diagnostic imagery become part of the EHR data set, they become part of HIE supported by CORHIO and QHN. In anticipation of this need, our collaborating organizations have developed the Colorado Image Exchange (CIE), operated by the Colorado Telehealth Network. The design of CIE allows

CORHIO and QHN--member providers to access stored images associated with EHRs using the HIE functionality of CORHIO. The CIE currently supports important diagnostic image modalities such as radiology and cardiology. Under the proposed effort, we will add mammography to the supported image types.

Image storage and retrieval is critically important for mammography. Effective breast cancer screening requires prior images to be compared with current state in order for proper analysis by radiologists. It is the slight changes in breast tissue that can provide the early warning signs of breast cancer. Many women without health insurance, or who have Medicaid, get their mammograms at whichever sites are most convenient or lowest cost such as mobile units or outreach clinics. This means that having priors available at each new screening is almost non-existent and, therefore, so is the ability of the imaging professional to see changes over time. Also, when prior mammograms are not available, repeat screenings or other imaging procedures are often required adding to healthcare costs and needless radiation exposure

In Chicago a group of hospitals along with the Chicago Health Information Exchange plan to launch a cloud based image repository for mammograms. Using the Chicago HIE Master Patient Index, patients can be identified regardless of where they received services. Access to this shared repository then allows the imaging professionals instant access to these prior images if they exist.

In Colorado we are uniquely situated to provide this same service to our healthcare organizations and their patients. Through the CIE, stored images from many Colorado hospitals will be accessible at the point of care. By establishing a specific Mammography Repository, we can extend this service into smaller clinics in underserved areas and increase the availability of these priors regardless of where a women received care. Access to these priors means a reduction in duplicate testing and therefore cost. It means better preventative care by providing imaging professionals with the historical data they need to make accurate diagnoses thus increasing patient care.

Because of the established infrastructure already funded and ongoing in Colorado from both CORHIO and CTN, all that is needed is funding of the endpoints to be able to share these images into the already established cloud. Such funding is requested as part of the proposed SIM effort. Access to images through the CIE places Colorado in the national forefront by implementing an aggressive and innovative solution to include images in HIE.

Chapter 7 Appendix

1. Current Patient Experience Innovations in Colorado

Multi-Payer Primary Care Medical Home Pilot

The Colorado PCMH Pilot was one of many national endeavors initiated to demonstrate financial viability and improved quality of care. It tested the model in 16 family medicine and internal medicine [practices](#) along the Colorado Front Range. Seven health plans — Anthem-Wellpoint, United Healthcare, Humana, Aetna, CIGNA, Colorado Medicaid and CoverColorado — also participated, agreeing to pay practices a per-member per-month fee for up to 20,000 covered patients. That money helped the practices establish and maintain patient-centric activities such as care management and care coordination. Payment for the pilot began in May 2009, once practices met requirements to achieve at least a Level 1 NCQA* Medical Home designation. HealthTeamWorks convened the Colorado Multi-Payer Patient-Centered Medical Home (PCMH) Pilot with participants at both the local and national levels. The project began in 2009 and officially concluded in April 2012. However, the pilot's success has made the PCMH the standard for primary care delivery in Colorado, and HealthTeamWorks now is dedicated to spreading the model statewide.

Medicaid Accountable Care Collaborative

The Accountable Care Collaborative ([ACC](#)) is a new Medicaid program to improve clients' health and reduce costs. Medicaid clients in the ACC will receive the **regular Medicaid benefit package**, and will also belong to a "Regional Care Collaborative Organization" ([RCCO](#)). Medicaid clients will also choose a Primary Care Medical Provider (PCMP).

The ACC is a central part of Medicaid reform that changes the incentives and health care delivery processes for providers from one that rewards a high volume of services to one that holds them accountable for health outcomes.

Safety Net Medical Home Initiative

The objective of the Safety Net Medical Home Initiative was to develop and demonstrate a replicable and sustainable implementation model to transform primary care safety net practices into patient-centered medical homes with benchmark performance in quality, efficiency, and patient experience. The Initiative was administered by Qualis Health and conducted in partnership with the MacColl Center for Health Care Innovation at the Group Health Research Institute. Five regions were selected for participation (Colorado,

Idaho, Massachusetts, Oregon and Pittsburgh), representing 65 safety net practices across the U.S. For more information about the Safety Net Medical Home Initiative, refer to: www.safetynetmedicalhome.org.

Bridges to Care

The Bridges to Care project in Aurora, Colorado follows an initiative developed in Camden, New Jersey by Dr. Jeffrey Brenner called “Hotspotters” that focuses on getting patients and resources out of overcrowded emergency rooms and into quality primary care. In the “hot spot” model care teams visit patients in high-need, high-cost neighborhoods to improve their access to health care and manage their chronic conditions.

Together Colorado will build relationships with patients and bring everyday voices to the public square on affordable and quality health care.

The Bridges to Care Project is funded primarily by the Center for Medicare and Medicaid Innovation (CMMI) through a program called "The Healthcare Innovation Challenge". The overall Innovation Award was for \$14.3 Million for three years. Aurora will receive \$3.3 over the three years of the project. The community-organizing portion of Bridges to Care is being funded by Atlantic Philanthropies, which is funding the same three years for the PICO national network affiliates working at each site.

21st Century Care

Denver Health’s *21st Century Care* will provide team-based care, coordinate care across health settings and offer self-care support between visits enabled by health information technology (HIT) and team-based patient navigators who will reach out to patients in a variety of ways. It will also integrate physical and behavioral health services in collaboration with the Mental Health Center of Denver in existing primary care settings and create new high-risk clinics for the most complex patients. Once in place, *21st Century Care* will improve both access to and quality of care for Denver Health’s largely low-income population and lower costs by reducing avoidable emergency room and hospital visits.

The Center for Medicare and Medicaid Innovation (CMMI) awarded the Denver Health \$19.8 million to transform its primary care delivery system to provide individualized care to more effectively meet its patients' medical, behavioral and social needs.

Advancing Care Together

Advancing Care Together (ACT) is a dynamic collaboration by the behavioral health, substance use, and primary care communities to take action together to discover practical ways to integrate care for people whose health problems and health care needs span physical, emotional, and behavioral domains. Over the lifespan, this includes almost everyone.

ACT a four-year program sponsored by the Colorado Health Foundation. ACT funds a portfolio of 11 demonstration projects that aspire to achieve and extend the principles of the patient-centered medical home to integrate mental health, substance use, behavior change, and primary care services. The ACT portfolio is made up of primary care practices and community mental health centers in Colorado servicing diverse geographic areas and employing a range of care delivery models.

Jefferson Center for Mental Health

Jefferson Center for Mental Health has long recognized the connection between mind and body and the importance of integrating behavioral and primary medical care to improve patient outcomes and control costs. Since 1995, Jefferson Center has provided integrated health care to benefit clients through our successful partnerships with health care entities and organizations such as Federally Qualified Health Centers (FQHC's), substance abuse providers, school-based health clinics, and community primary care practices.

Working with our community partners, Jefferson Center has pursued bidirectional integration, bringing mental health services into the medical setting while also making physical health services available on-site at the mental health center offices. Bidirectional integration takes into account patient preferences and helps mitigate transportation, stigma, cost and other barriers to care while improving overall health outcomes. Jefferson Center's integrated health services occur on a continuum and range from facilitated and mutual referrals to co-located services, to more highly integrated services.

Nurse-Family Partnership

Nurse-Family Partnership helps transform the lives of vulnerable first-time moms and their babies.

Through ongoing home visits from registered nurses, low-income, first-time moms receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children, and become more economically self-sufficient. From pregnancy until the child turns two years old, Nurse-Family Partnership Nurse Home Visitors form a much-needed, trusting relationship with the first-time moms, instilling confidence and empowering them to achieve a better life for their children – and themselves.

An evidence-based community health program, Nurse-Family Partnership's outcomes include long-term family improvements in health, education, and economic self-sufficiency. By helping to break the cycle of poverty, we play an important role in helping to improve the lives of society's most vulnerable members, build stronger communities, and leave a positive impact on this and future generations.

The Nurse-Family Partnership National Service Office is a non-profit organization that provides implementing agencies with the specialized expertise and support needed to deliver Nurse-Family Partnership with fidelity to the model – so that each community can see comparable outcomes.

Engaged Benefit Design

Engaged Benefit Design (EBD) is a new approach to healthcare benefits that provides resources and incentives for patients and their healthcare providers to make healthcare decisions based on patient values and medical evidence. Treatments with strong scientific evidence to support their use, such as prenatal care and insulin to treat diabetes, are called "No Co-Pay, High Value," and are available at no additional cost to the patient. Other treatments, that may be right for some but not for others, are called "Costs More, Learn More." A patient and a provider may choose these treatments but there is additional expense to the patient. Free-of-charge educational material is available to encourage consideration of alternatives before making a final decision. You may be eligible for a gift card or other incentive just for learning more about your options.

Asian Pacific Development Center

The Asian Pacific Development Center of Colorado (APDC) is a 501(c)(3) nonprofit organization supporting the Asian American Pacific Islander community. For 30 years we have been committed to providing culturally appropriate health, mental health, and related services to our communities. We employ a holistic approach to address the total well-being of individuals and families. APDC also understands that there continue to be barriers of language, culture, and generational issues underlying social determinants that impact well-being. So, when we begin to address poverty, education, employment, and access to a plethora of different support systems, we contribute to the empowerment and overall health of everyone. Our vision is for our communities to be healthy and empowered.

Integrated Care Services means the blending of our existing mental health and other services with primary care medical services to create a coordinated, comprehensive system of care. We are committed to offering easily accessible and affordable health care blending Eastern, Western, and Pacific Islander

traditions. While intended to serve the AAPI communities in general, Integrated Care Services will target especially the indigent, refugees, and first-generation Americans.

PATH

The PATH program employs two full-time, Masters-level Licensed Clinical Social Workers from Spanish Peaks Mental Health Center. These clinicians interface with Posada, an agency providing housing and supportive services that empower homeless individuals and families in Pueblo County, and work with physical health providers from the Pueblo Community Health Center, a Federally Qualified Health Center (FQHC) to provide integrated care.

Adams County School Based Health Clinic

This school-based health clinic (SBHC) located at Adams City High School is a collaborative effort between the Adams County School District, Community Reach Center (CRC) and Community Health Services. The SBHC is housed in the school building, follows the school calendar, and is known as The Wellness Center. Psychiatry services are available to adolescents seen as part of the integrated care model of treatment.

2. Organizations Involved in the Process

The following organizations contributed to this chapter through key informant interviews, group conversations or through review of the chapter:

Alzheimer's Association – Colorado Chapter

American Cancer Society – Colorado

American Heart Association-Denver

Arthritis Foundation of Colorado

Colorado Center on Law and Policy

Colorado Children's Campaign

Colorado Community Health Network

Colorado Consumer Health Initiative

Community Health Partners

Denver Health

Engaged Public

Family Voices

Health TeamWorks

Jefferson Center for Mental Health

National Multiple Sclerosis Society – Colorado, Wyoming Chapter

Mental Health America Colorado

Rocky Mountain MS Center

The Leukemia and Lymphoma Society – Rocky Mountain Chapter

University of Colorado School of Medicine Department of Family Medicine

3. Focus Group Demographics

Gender

- Female – Twelve
- Male – Eleven

Age

- 51-60 – Eight
- 41-50 – Seven
- 26-40 – Seven

Education

- College Graduate – Eight
- Some College – Twelve
- High School Graduate – Three

Income

- Above \$75,000 – Five
- \$50,000 – \$75,000 – Seven
- \$25,000 - \$50,000 – Nine
- Below \$25,000 – Two

Ethnicity and Race

- African American – Six
- Hispanic – Three
- Caucasian – Eleven
- Asian – Two
- Native American – One

Current Health Insurance

- Yes – Twenty-two
- No – One

Have you had any time in the last year when you did not have health insurance?

- Continuously covered in last year - Eighteen
- Period of uninsurance in the last year – Four
- No response – One

Number of health care visits in the last year

- 3+ – Nine
- 1-3 – Fourteen

Overall health

- Excellent – Nine
- Good – Fourteen

Stakeholder Report

Colorado's SIM Planning: Stakeholder Involvement

Colorado's SIM team tapped a wide range of experts and innovators from throughout the state to help craft the Colorado Health Care Innovation Plan. The overarching goal was to take advantage of Colorado's best thinking while building the widespread support necessary to achieve transformation of the health care system.

Stakeholders participated in SIM planning through a number of paths, including an overall advisory group consisting of 200 Colorado health care leaders; a smaller steering committee that provided ongoing advice and feedback to the SIM management team; and targeted stakeholder groups for payer, provider, public health, patient experience and focused population tracks.

A communications plan updated the interested public through a website and social media postings.

Finally, numerous personal discussions between team managers and thought leaders from across the state's health care community helped set the stage to capitalize on Colorado's strong and ongoing spirit of collaboration.

In total, nearly 200 stakeholders participated in Colorado's SIM planning process.

The Colorado SIM Team

At the project level, the SIM management team of health care policy leaders met weekly to coordinate the innovation plan, focusing on strategic thinking, problem-solving and ensuring that Colorado's final plan meets the highest level of quality.

Lorez Meinhold, Deputy Executive Director of the Colorado Department of Health Care Policy (HCPF), leads the SIM project. Meinhold previously served as Senior Policy Director for Health, Human Services, Education and Economic Development in the Office of Policy and Research for Colorado Governor John Hickenlooper; Senior Health Policy Analyst for former Colorado Governor Bill Ritter; Senior Program Officer for the Colorado Health Foundation; and Executive Director of the Colorado Consumer Health Initiative.

Other team members:

Laurel Karabatsos, Director of the Health Programs Services and Support Division, HCPF. She is overseeing implementation of the Accountable Care Collaborative (ACC) delivery system reform as well as establishing a process to define Medicaid benefit coverage policies using evidence-based care.

Michele Lueck, President and CEO, Colorado Health Institute, a nonpartisan organization that provides health care policy data, analysis and expertise. Previously, she held leadership roles in two health-related nonprofits. Before entering the nonprofit world, she worked in account management at Sg2 and Thomson Reuters.

Ben Miller, Director of the Office of Integrated Healthcare Research and Policy, Department of Family Medicine, University of Colorado Denver School of Medicine. Dr. Miller is a national expert on the integration of primary care and behavioral health care. He is an assistant professor and is also Associate Director of Research and Primary Care Outreach for the University of Colorado Denver's Depression Center.

Edie Sonn, Vice President of Strategic Initiatives, Center for Improving Value in Health Care. Responsible for developing policy and building collaborative relationships, she has spent 20 years working on health policy issues on behalf of clients in virtually every facet of the health care industry, as well as on broad-based health reform in the policy and political arenas. She staffed the Blue Ribbon Commission for Health Care Reform and most recently served as senior director of public affairs at the Colorado Medical Society.

The SIM management team formulated a proposed innovation model and a state innovation plan based on research and evidence related to integrating primary care and behavioral health care. This work began with the creation of the initial SIM proposal and continued with more in-depth consideration by the team and all stakeholders as part of the pre-testing award.

In particular, Dr. Miller brought his ground-breaking work on integration to the table, providing evidence on how the outcome of the integration of primary care and behavioral health will lead to a health system transformation for the state.

The entire team worked throughout the process to keep lines of communication open with key health care delivery and policy leaders, ensuring strong support from the community for Colorado's innovation efforts.

Colorado's SIM Project: The Stakeholder Process

The Advisory Group:

Over 150 stakeholders, representing providers, payers, advocates, consumers, legislators, foundations and businesses have provided input and feedback on the progress of Colorado's State Healthcare Innovation Plan, which will serve as the State's roadmap for transforming the delivery and payment of integrated health care. This group met three times – May 29, August 6 and November 4. These meetings, each ninety minutes long, served a number of important purposes. They were used to communicate the process involved in creating the model and the plan, to explain the strategy related to both, to get feedback, to get buy-in and, finally, to gain a commitment going forward.

This directly related to the project requirement that the state's health care providers would commit to the delivery system transformation.

Group members were apprised at the first meeting of the expectations for their participation, including their crucial role in shaping the model and the plan.

The management team laid out this range of stakeholder engagement:

- Feedback, comments, questions
- Smaller groups on the nuts and bolts
- Population research
- System capacity and readiness analysis
- Support: In-person, online
- Website: ColoradoSIM.org

During the meeting, Dr. Miller explained the evidence and the rough draft of the innovation model. He talked to stakeholders about the impact of fragmenting primary care and behavioral health care, including that:

- Between 50 percent and 90 percent of patients with mental health needs rely solely on their primary care physician. (Brody, D.S., Khaliq, A.A., & Thompson, T.L. (1997).
- Primary care has become the de facto mental health system. (Reiger, D. A., Narrow, W. E., Rac, D. S., Manderscheid, R. W., Locke, B., & Goodwin, F. (1993).
- Two-thirds of primary care physicians (N=6,660) reported not being able to access outpatient behavioral health for their patients. (Cunningham, Health Affairs. 2009; 3:w490-w501).

The first meeting on May 29 ended with consensus on the direction presented by the SIM management team. Stakeholders were told that they would ultimately be asked to approve the final report, containing the proposed model and innovation plan, at the third meeting.

The second meeting, on August 6, focused on making sure that all of the stakeholders had a clear understanding of the SIM process and goals, offered an update of stakeholder work accomplished between the meetings, and the work remaining to be done, and featured an in-depth discussion of the proposed innovation model.

A rough draft of the driver diagram was introduced to aid the discussion.

The majority of the meeting was spent explaining the proposed innovation model and having a facilitated discussion with the stakeholders about it.

Three working assumptions about the value of integration were presented by Dr. Miller:

- The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

- This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, ineffective patterns of health care utilization.
- Integrating physical and behavioral care is good health policy and good for health.

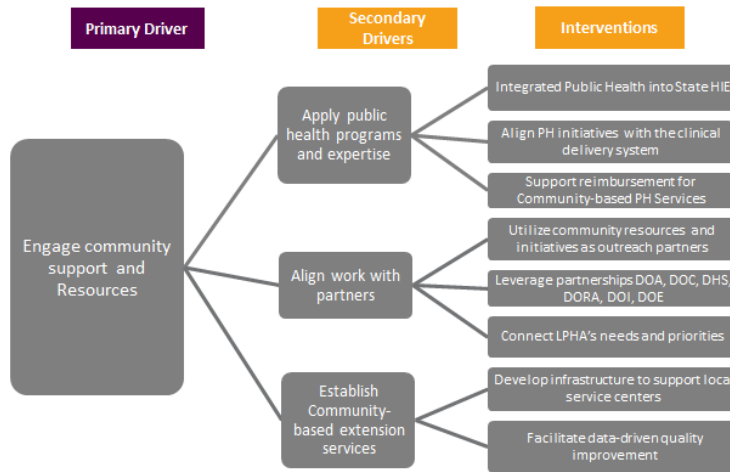
Dr. Miller introduced the *Lexicon for Behavioral Health and Primary Care Integration*, a foundational and actionable report by The Academy - Integrating Behavioral Health and Primary Care – in the Agency for Healthcare Research and Quality (AHRQ). He also described the components of integration; the supporting components; the scopes of integration; and the expectations within each scope. Finally, he described an integrated team and broke down, in broad terms, duties and responsibilities.

An ensuing discussion with stakeholders clarified Colorado's vision and addressed questions and concerns. This helped us to meet our deliverable of clarifying how the outcome of the integration of primary care and behavioral health will lead to health system transformation for Colorado as well as how the model can reach the goal of making integrated care available to 80 percent of our population in five years.

The third and final meeting on November 4 reviewed refinements to the overall SIM plan and clarified the approach to the larger SHIP visions through the presentation of expanded, detailed driver diagrams (below). This expanded and refined explanation of the SIM vision prompted discussion with the stakeholders that were present and led to informative discussion about areas that were or were not included in the completed draft.

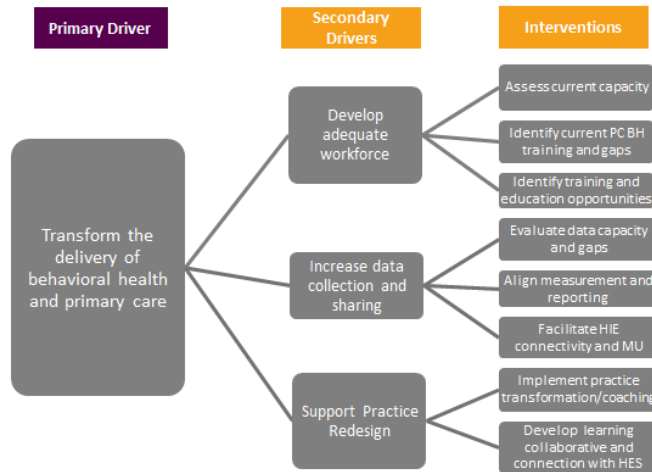
Following this meeting, stakeholders were given access to a full draft of the SIM plan and asked to review the document and comment on the content. We received thoughtful responses from a number of organizations across the state and integrated many of those comments and suggestions into the final draft. This review process also helped identify areas of the plan that were not clear or may have been misinterpreted. Stakeholder review was critical to ensure that we had a thorough and clear presentation of our SHIP.

Diagram: The Innovation Plan

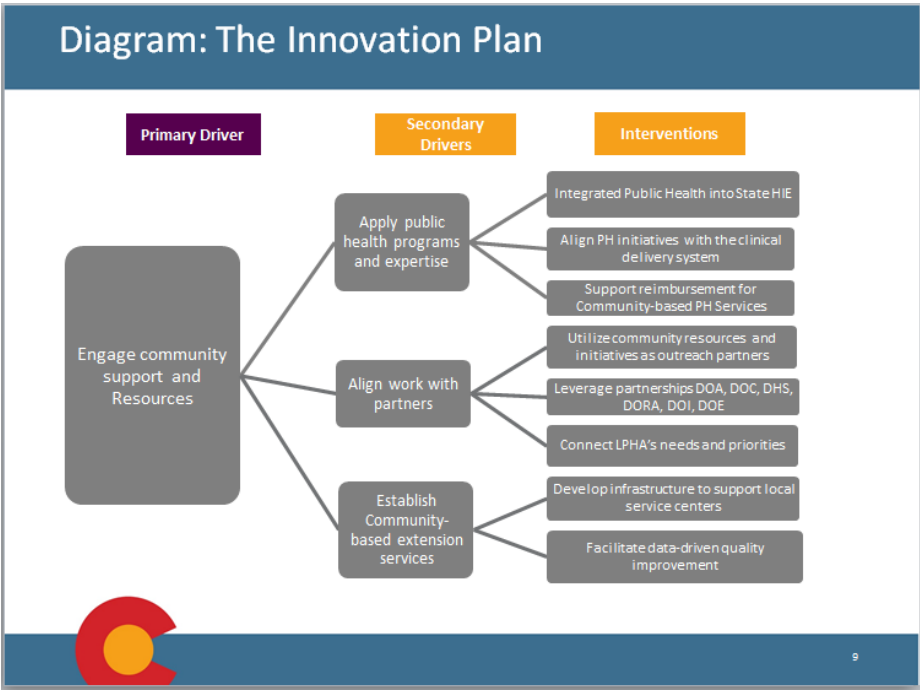
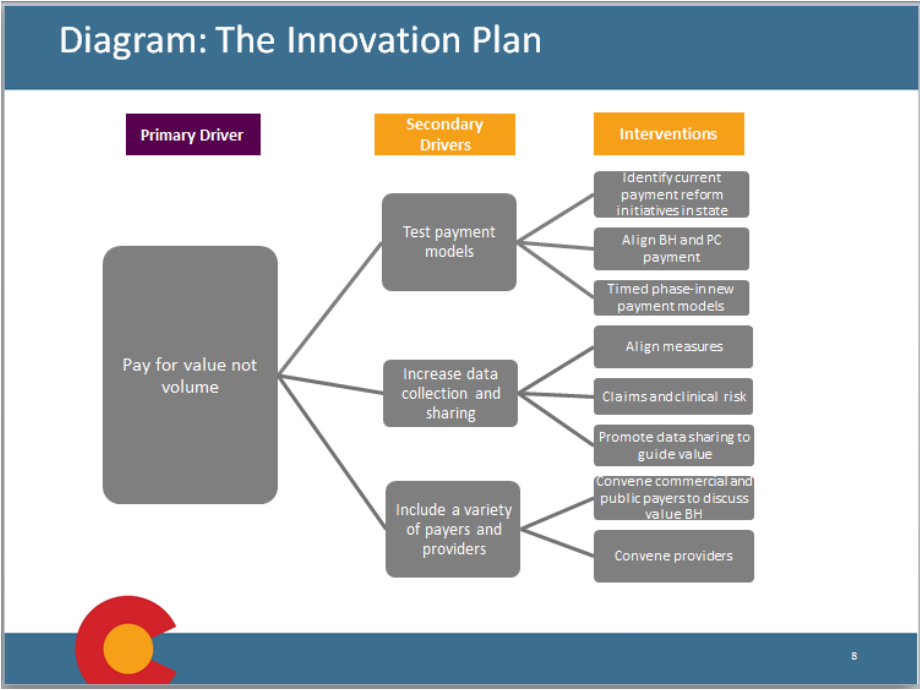


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Diagram: The Innovation Plan



7



The Steering Committee:

The Steering Committee was made up of a select group of individuals from our stakeholder groups, including insurers (public and private), state government and health officials, medical and behavioral health professionals and others. Because this group was significantly smaller than the Advisory Group, we were able to get more in-depth information and feedback from them. This group met on July 23rd,

October 7th and November 7th to review progress being made on the SIM and SHIP. Through the process of developing the SIM, this group was asked for specific feedback on the outline of the approach, draft chapters on payment and delivery reform and the full draft of the SHIP. At each stage, this group offered insightful feedback that directly affected the development of our plan for the state.

Targeted Stakeholder Groups:

We also conducted targeted stakeholder meetings to focus on payers, providers and public health. The goal presented to members of each stakeholder group was to arrive at shared recommendations to support successful implementation of the model and the plan.

Payer Stakeholder Group

Payers were engaged in this process through the advisory committee, steering committee and through the various workgroups. We had conversations with large and small payers to help develop and align the payment models presented to the steering and advisory committees in October and November. In addition, we have worked with the Colorado Association of Health Plans to have a series of conversations on information needed for the return on investment calculations.

Provider Stakeholder Group

This group of stakeholders met three times, on June 5, July 12 and August 15, focusing on issues of concern to primary care providers, behavioral health care providers and others in the statewide health care community. Questions about the adequacy and training of the state's health care workforce were a top priority, but this group also addressed the provider experience with the state's efforts around health homes, IT, payment design, benefit design, quality improvement, quality measurement and the consumer experience.

The group included nearly 50 expert stakeholders representing behavioral and physical health providers, state government, practice transition specialists, patient representatives, academic institutions and philanthropic organizations.

Each three-hour meeting covered a wide range of topics, including the real-world implications of what the proposed innovation changes would mean for providers and patients.

The workgroup reached consensus on more than 40 specific recommendations focusing on workforce needs, facilitating individual practice transformation, regulatory changes, and evaluation.

Recommendations from the health care provider workgroup provided the foundation for Colorado's workforce strategy, which includes innovative approaches to creating a health care workforce that is effective and efficient. The group's recommendations addressed policies for training, both academically and at the clinical level; professional licensure; and strategies for scope of practice status reviews.

This group also reached consensus on the overall goal and vision of both the innovation model and the innovation plan. The reports from the provider plan are attached in the Appendix as PDFs.

Public Health Stakeholder Group

The public health workgroup met five times on June 5th, June 21st, July 11th, August 6th and September 9th. This group was a group of representatives from a broad range of organizations and experts from within and outside of the public health system. The intent of this multi-disciplinary group was to broaden the traditional public health dialogue and engage a group of current and potential public health partners in developing the connection between the public health system, and concepts of prevention and population health, with the broader health system.

Workgroup meeting content and activities included facilitated brainstorming and information processing activities, expert presentations, and open dialogue and discussion. Some members utilized an online discussion board to publically document their thoughts and perspectives, and members were encouraged to contact staff directly with comments, questions and thoughts related to the conversation. Individual experts, within and outside of the workgroup, were recruited to draft specific sections of the report and plan. Additional public health experts were also used to provide input on the workgroup report.

The complete report and recommendations from this group are included in the Appendix.

Patient Experience Stakeholder Group

The Colorado Coalition for the Medically Underserved conducted two different focus groups with patients to gain the consumer perspective on the SHIP. The details of those focus groups and the results of those discussions can be found in the Appendix to Chapter 7.

Final Report: Public Health Work Group

PREFACE

Background on SIM and Purpose of Workgroup

In late 2012, the State of Colorado, led by the Department of Health Care Policy and Financing (HCPF), submitted a proposal to the Centers for Medicare and Medicaid Services (CMMS) under the State Innovation Model Testing Cooperative Agreement (SIM) opportunity. The proposal was not funded as written, however, Colorado was provided with comments on the proposal and an opportunity to work to strengthen the proposal and Colorado's innovation plan, for future funding opportunities. In March 2013, the state received a State Innovation Model Pre-Testing Assistance Award. The grant supported six months of planning and continued work to improve the innovation plan, further develop the initial innovation proposal, and refine the innovation testing model of the integration of behavioral health and primary health care.

To complete the planning and activities for the Pre-Testing Assistance Award, HCPF created a set of stakeholder workgroups with distinct tasks and consultant facilitators. An open and full, Stakeholder Advisory Group was convened three times for broad dialogue, sharing, and report out of the progress of the targeted workgroups. Smaller, technical workgroups were assigned the following topic areas: Payers, Providers, Public Health and Specific Populations. The Management Team worked to connect ideas among the targeted workgroups. This report describes and summarizes the results of the Public Health Workgroup.

Public Health Workgroup Membership

The SIM Public Health Workgroup was, by design, a group of representatives from a broad range of organizations and experts from within and outside of the public health system. Members of the workgroup are listed in the Appendix. The intent of this multi-disciplinary group was to broaden the traditional public health dialogue and engage a group of current and potential public health partners in developing the connection between the public health system, and concepts of prevention and population health, with the broader health system.

Workgroup Meeting Plan and Facilitation

The SIM Public Health Workgroup accomplished its work through five, in-person and conference call meetings facilitated by Lisa VanRaemdonck, Executive Director of the Colorado Association of Local

Public Health Officials (CALPHO), and staffed by Edie Sonn, Kristin Paulson and Cortney Green from the Center for Improving Value in Health Care (CIVHC). Edie Sonn was a member of the Management Team and was responsible for bringing the public health workgroup voice to the larger plan discussion.

Workgroup meeting content and activities included facilitated brainstorming and information processing activities, expert presentations, and open dialogue and discussion. An online discussion board was utilized by some members to publically document their thoughts and perspectives, and members were encouraged to contact staff directly with comments, questions and thoughts related to the conversation. Individual experts, within and outside of the workgroup, were recruited to draft specific sections of the report and plan. Additional public health experts were also used to provide input on the workgroup report.

Structure of Report

This report is structured as a summarization of the conversations and ideas explored within the SIM Public Health Workgroup. The report also serves to document answers to the specific questions that were asked by the CMMS in feedback on the original State Innovation Model (SIM) proposal. Portions of information in this report will be submitted with the updated innovation plan and the information here can be used by partners across the state in efforts to further integrate the public health system, prevention, and population health work within the health system.

Defining Public Health and Prevention

Even among public health professionals, there are varying opinions on the definitions of public health, population health and other related terminology. The Public Health Workgroup explored some of these definitions in an effort to ensure that workgroup members could align their own definitions of these important concepts. The workgroup did not intend to purport that these are the only definitions, nor the “right” definitions. Rather, it was important to have a general agreement about some terminology. Following are two key definitions that were discussed during workgroup sessions.

Public Health System: “The public health system is distinct from the public health department, in that it includes all the community organizations and agencies that contribute to the “conditions in which people can be healthy.” It includes all of the public and private resources that contribute to the delivery of public health services.”¹⁷

Population Health: “The health outcomes of a group of individuals, including the distribution of such outcomes within the group. *Population health* also encompasses the multiple determinants of health that produce these outcomes.”¹⁸ Population health extends to the larger population of community members, not just a “selected” population such as a patient population in a primary care practice.

Additional terminology such as community health, prevention and health equity were also discussed among the workgroup members. It would be useful for Colorado public health and partners to continue the process of finding a common understanding of key definitions. This common understanding will be important in moving forward with integration of public health.

¹⁷ Scutchfield and Keck. Principles of Public Health Practice. 2009. Vol. 3rd edition. Clifton Park, NY: Delmar.

¹⁸ Kindig and Stoddart, Models for Population Health, American Journal of Public Health, March 2003, 93(3)380-383.

Questions from SIM Response

The original SIM proposal feedback included questions that were to be directly answered by the SIM Public Health Workgroup. These answers will be detailed in the full plan and are documented in various ways throughout this report.

State of Health in Colorado

The state of health in Colorado from the public health perspective is focused on population health outcomes that can be impacted through prevention, health promotion and environmental change in communities.

Many recent and ongoing efforts in Colorado have described the “state of health” through various lenses. The Colorado Department of Public Health and Environment’s work on Colorado’s Ten Winnable Battles outlines current population health outcomes that can be improved within the next five years, through targeted public health and prevention activities. Governor John Hickenlooper’s “The State of Health” connects to some of the Winnable Battles and describes additional primary care system and payment system related goals. The Colorado Children’s Campaign, the Colorado Health Foundation’s Colorado Health Report Card, and other state reports include data and analyses that describe the health of Colorado. These reports and related data systems are often focused on targeted populations, individual health outcomes of interest, or risk factors related to health outcomes.

In addition, all Colorado Local Public Health Agencies (LPHAs) are required, by state law, to perform periodic community health assessments using methods that engage community members and leaders in the assessment process. These assessments were most recently performed between 2011 and 2013 and have included primary data collection and compilation of secondary data from various national, state and local sources. Some LPHAs have produced printed or online community health assessment reports. The state health department is also required by law to produce a state health assessment. This assessment, currently being developed, is using the local community health assessments and other related work as a basis and will include quantitative and qualitative data. The state health assessment will be published in 2014.

With all of the existing health data reports available, we see tremendous strengths and challenges in Colorado health. This report focuses on a few of the challenges to the state of Colorado’s health that are most related to the goals of the overarching innovation plan.

From the outside, and on the surface, Colorado can seem like a very healthy state. This is due in large part to a climate and terrain that favor many outdoor opportunities such as skiing, hiking and biking. In addition, many of Colorado’s urban areas have invested in infrastructure such as bike paths and park areas that support and encourage activity. Colorado’s 300 days of sunshine and culture of physical activity help

more than 27 percent of Coloradans regularly meet the federal physical health guidelines – more than any other state in the nation¹⁹.

Although Colorado ranks 10th among states in healthy living, it ranks 28th in prevention and 40th in health care access²⁰. The health disparities that exist across Colorado communities are substantial in multiple areas of health. These disparities drive the reality of Colorado health below the surface and are offer real potential for improving health in the state.

To understand the context of health in the state, it is important to recognize that Colorado is a large state with distinctly different regions and economies. The vast majority of the state’s residents live in the metropolitan areas that mostly fall along the north-south I-25 corridor that bisects the state. However, in the mountainous areas to the west and the plains to the east the majority of our landmass is rural. These areas experience challenges of access to care from challenges of access to care and populations that tend to be older and sicker than those in urban areas – not an uncommon issue in other parts of the country. With our popular outdoor activity and tourism industries, Colorado has rural “resort” communities that have unique needs to support the health of year-round residents, temporary resort workers, vacation home owners and active tourists. Two tribes also have land in Colorado – the Ute Mountain Ute and Southern Ute reservations are in the southwest corner of Colorado on the border with New Mexico.

Obesity in Colorado

One growing obstacle to becoming the healthiest state in the nation is the state’s continuously rising obesity rate. While Colorado is known to have the lowest rate of obesity in the nation, that rate continues to rise and recently exceeded 20 percent, a number that would have made us the fattest state in the nation just 15 years ago²¹. Altogether, more than 60 percent of the state is either overweight or obese, including almost

Colorado nonprofit tackles obesity

LiveWell is a Colorado nonprofit committed to reducing obesity in Colorado by promoting healthy eating and active living. LiveWell has partnered with several health systems and the State to develop programs to make healthy living the easy choice for Coloradans. Their programs and interventions include efforts to improve school lunches and increase school day activity, encouraging healthy snacking and “walking meetings” at the workplace, and engaging communities in healthy living efforts. The support this organization has received from the State and others is a demonstration of the commitment to improve the health of Coloradans.

¹⁹ Centers for Disease Control and Prevention (CDC). Adult participation in physical activity -- United States, 2011. MMWR Morb Mortal Wkly Rep. 2012;60(17):347-352. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6217a2.htm>

²⁰ Colorado State Scorecard, 2009. The Commonwealth Fund. Available at <http://datacenter.commonwealthfund.org/scorecard/state/7/colorado>

²¹ Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2013.

one in three children²². There is some indication that efforts to address obesity may be having a positive effect. In 2007, 14.2 percent of Colorado's children between 10 and 17 were obese – that rate fell to 10.9 percent in 2011²³. Unfortunately, recent data from the CDC may indicate that the decline in child obesity doesn't extend to all ages; obesity among low income preschool children from 2-4 years of age has increased from 9 to 10 percent since 2009²⁴.

²² Behavioral Risk Factor Surveillance System Survey Data, 2011. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

²³ 2011/12 National Survey of Child Health. Child and Adolescent Health Measurement Initiative, Data Resource Center on Child and Adolescent Health website. Accessible at: <http://childhealthdata.org/learn/NSCH>

²⁴ Centers for Disease Control and Prevention (CDC). Obesity prevalence among low-income, preschool-aged children—United States, 2008-2011. MMWR 2013;62(31):629-634 .

Mental Health in Colorado

Mental health is also a challenge for Colorado: three in ten Coloradans need treatment for mental health or substance use disorders each year, yet less than half of them are able to access care²⁵. Colorado continues to fall behind in mental health spending, currently ranking 32nd out of the 50 states and spending less than 1/3 the national average to treat substance abuse disorders²⁶. Mental health concerns extend to the adolescent population where the Colorado suicide rate is the 8th highest in the nation²⁷. The biggest obstacle to improving these issues is the lack of adequate data on mental health access and services. We know that racial minorities and

Mental health in Colorado corrections

Colorado correctional facilities house close to 20,000 Coloradans, the majority of whom are white and Hispanic males under age 40. Moderate to severe substance abuse is a problem in over 74 percent of males and 80 percent of females. Moderate to severe mental health issues are present in 30 percent of male inmates and 70% of female inmates. Variations in length of incarceration make screening and continuous care for mental health and substance abuse issues challenging and there are few resources for connecting released inmates with community care. LPHAs, community based organizations, and mental health centers could play a key role in fostering such relationships and providing data on the current situation and the effectiveness of interventions.

the poor have a more difficult time accessing available mental health services, but the information we have is incomplete and almost certainly understates the need among those populations²⁸.

Children in Colorado

Colorado's children are among those most in need across the state. According to the 2013 Kids Count report, Colorado ranks in the bottom ten states for children's health²⁹. The number of Colorado youth living in high poverty areas is growing faster than any other state in the nation and has more than quadrupled since 2000. Living in high poverty areas decreases the chances of getting adequate access to health care, healthy foods and safe outdoor activities. In addition, the percentage of children living in poverty increased from 14 percent in 2000 to 18 percent in 2013, representing an additional 77,000

²⁵ TriWest Group, 2011. The status of Behavioral Health Care in Colorado – 2011 Update. Advancing Colorado's Mental Health Care: Caring for Colorado Foundation, The Colorado Health Foundation, The Colorado Trust and the Denver Foundation; Denver, CO.

²⁶ Id.

²⁷ Colorado Child Health Survey, 2011. Health Statistics Section, Colorado Department of Public Health and Environment.

²⁸ TriWest Group, 2011. The Status of Behavioral Health Care in Colorado – 2011 Update. Advancing Colorado's Mental Health Care: Caring for Colorado Foundation, The Colorado Health Foundation, The Colorado Trust and the Denver Foundation; Denver, CO.

²⁹ 2013 Kids Count State Profile, Colorado. The Anne E. Casey Foundation. Accessible at: <http://datacenter.kidscount.org/publications/databook/StateProfileSheets/2013>

children living in poverty.³⁰ Children below the poverty level are approximately six times as likely to be obese compared to children with incomes above 400 percent of the federal poverty level³¹. Those increases, combined with the higher than average rates of uninsurance among children and the high adolescent suicide rates, make Colorado's kids a clear priority for any effort to improve the health of Colorado.

Health Disparities in Colorado

Racial and ethnic minority populations in Colorado are growing and are disproportionately affected by poor health and poverty^{32,33}. Colorado's overall poverty rates topped 13.5 percent in 2011, but the black population in Colorado suffered much higher rates of poverty, with 27.3 percent of the black and African-American community living below the federal poverty line^{34,35}. The Latino population had the next highest rate at 24.3 percent. Meanwhile, white, non-Hispanics had a much lower poverty rate with only 9.4 percent of the population living in poverty³⁶. Minority populations also have a more difficult time accessing services and receiving needed care than their white counterparts. Black and Hispanic Coloradan's experience worse overall health, higher rates of obesity and inactivity as well as lower scores on key public health indicators such as infant mortality, low birth weight, diabetes and high blood pressure^{37,38,39}. In addition to racial and ethnic disparities, we know that people with low income, people living in rural areas, people who are gay, lesbian and transgendered, and others also experience disparities in risk factors, health outcomes and access to care.

Colorado lacks the data capacity to track mental health services to minority Medicaid beneficiaries and as a result has no clear picture of the level of mental health access available to these populations. We do know that youth and adults of color are disproportionately likely to receive their mental health care in a

³⁰ 2013 Kids Count State Profile, Colorado. The Anne E. Casey Foundation. Accessible at: <http://datacenter.kidscount.org/publications/databook/StateProfileSheets/2013>

³¹ 2011/12 National Survey of Child Health. Child and Adolescent Health Measurement Initiative, Data Resource Center on Child and Adolescent Health website. Accessible at: <http://childhealthdata.org/learn/NSCH>

³² Garner, E. Demographic Trends: Understanding the Impact of a Changing Population on Colorado, 2011, Colorado State Demography Office, Colorado Department of Local Affairs.

³³ Colorado Coalition for the Medically Underserved. Issue Brief Series: Health Connections, Health & Race, 2012. Available at www.cohealthaccesssurvey.org/reports/.

³⁴ U.S. Census Bureau, 2011 American Community Survey. Accessible at: www.census.gov

³⁵ Id.

³⁶ Id.

³⁷ Colorado Health Access Survey. 2011. Denver, CO: The Colorado Trust.

³⁸ Racial and Ethnic Health Disparities in Colorado, 2009. Denver, CO: Colorado Department of Public Health and Environment.

³⁹ Behavioral Risk Factor Surveillance System Survey Data, 2011. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

correctional facility⁴⁰. Colorado's two tribal communities share in this disparity, experiencing increased rates of mental health problems and diabetes as well as decreased access to care and specialists.

One of the states' top priorities in health is becoming the healthiest state in the nation. While we have a good start, there are a lot of challenges we need to overcome before we can reach that goal. We know that we can only reach this goal by working with communities and populations that experience health disparities in our state and aligning our work at the state level with system supports.

Current View of the Public Health Delivery System in Colorado

The public health delivery system in Colorado is built on a foundation of governmental public health agencies. These agencies, with community-based organizations, health care partners and other safety net providers provide prevention, population health and individual care services. As Colorado takes more of a "social determinants of health" lens, a broader range of governmental and community-based organization work is being connected with the health of communities.

There are examples and case studies of successful and innovative evidence-based and evidence-informed programs and initiatives throughout the state. These programs are tailored to meet specific community needs that have been identified by public health and partners. Examples of interdisciplinary collaboration exist within many communities. One of Colorado's biggest challenges in the current system is that these community-based programs are fragmented and details about successes are not widely shared to be tested in other jurisdictions. While we have plenty of activity at the state and local level, we lack a comprehensive plan and an infrastructure to strategically support the selection and scaling up of these individual programs for statewide impact.

To better understand the context in which these programs and initiatives currently exist, it is important to be informed about the foundational structure and function of the public health delivery system.

Structure of the Public Health Delivery System

Public health services in Colorado are provided through the Colorado Department of Public Health and Environment (CDPHE) and 54 local public health agencies (LPHAs) that operate separately and

⁴⁰ TriWest Group, 2011. The status of Behavioral Health Care in Colorado – 2011 Update. Advancing Colorado's Mental Health Care: Caring for Colorado Foundation, The Colorado Health Foundation, The Colorado Trust and the Denver Foundation; Denver, CO.

independently from the state agency. Both state and local public health provision is governed by the Colorado Public Health Act of 2008 (C.R.S. 25-1-501 et seq) and other statutes and rules codified at the state level. In addition to governmental public health, Colorado has numerous community-based organizations that work in the public health and prevention arenas.

Public Health Frameworks

Public health professionals use the 10 Essential Public Health Services (Figure 1) as a framework to describe the functions of public health. These services include monitoring health status, diagnosing public health problems as they emerge, educating people, connecting individuals to health services, shaping policies that promote health and evaluating the impact of these efforts. CDPHE and local public health agencies coordinate or support the provision of the 10 Essential Public Health Services in different ways and at different levels, throughout the state.

The delivery and prioritization of the 10 Essential Public Health Services is shaped by two conceptual frameworks: the socio-ecological model (Figure 2) and the Health Impact Pyramid (Figure 3). Given limited resources, prioritizing among strategies and across the range of available public health strategies is essential.

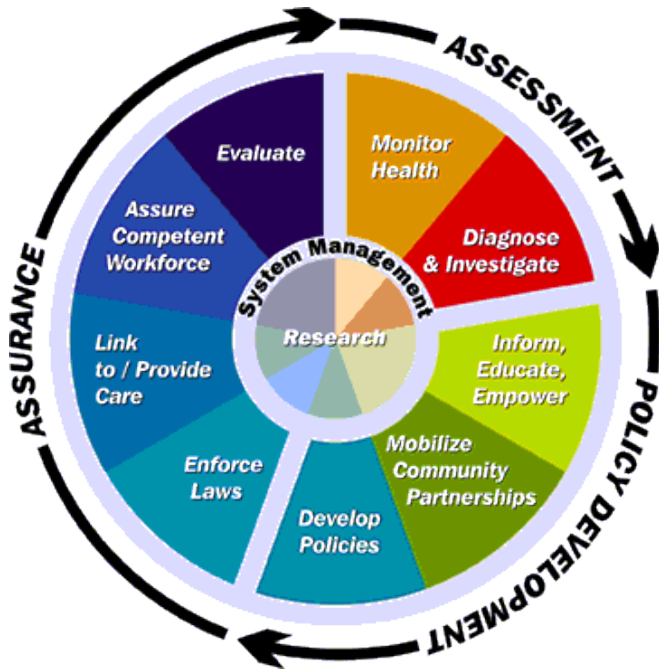


Figure 1: Core functions of public health and the 10 essential services

Source: Office of Disease Prevention and Health Promotion (2006). “Public Health in America.” Available at <http://web.health.gov/phfunctions/public.htm>

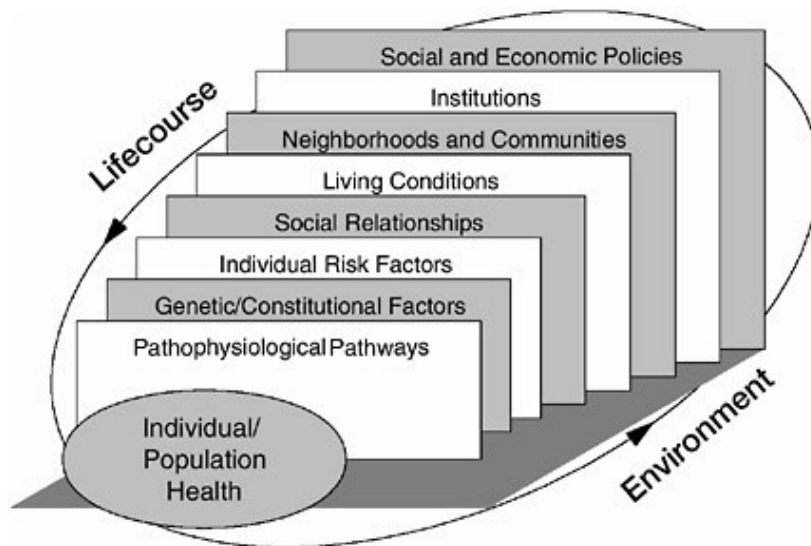


Figure 2: The Socio-Ecological Model

Source: [The Future of the Public's Health in the 21st Century](#) (2002)⁴¹ Board on Health Promotion and Disease Prevention ([HPDP](#)) Institute of Medicine ([IOM](#))

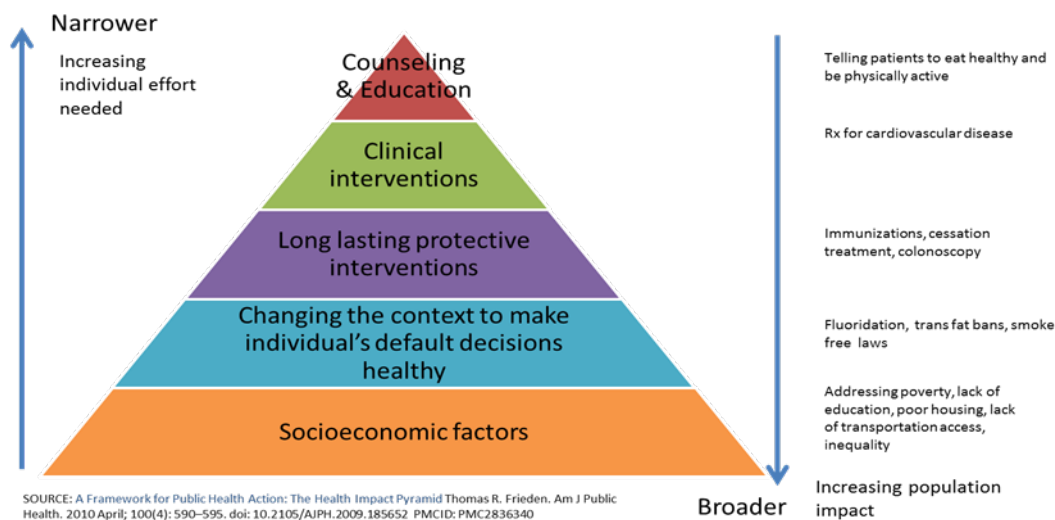


Figure 3: CDCs Health Impact Pyramid

These concepts remind public health professionals that, although potential services range across a broad spectrum, the greatest needs and the most efficient use of resources often reside in the broad, foundational elements of social environments. Strategies that set the conditions for healthy choices, behaviors, and environments have a broad impact on population health. These population health strategies effectively improve health and reduce burdens on and costs by the health care system. Such population health strategies include policy initiatives, innovations in health systems, surveillance, capacity building, community organizing, education, workforce development and quality assurance.

As services become more targeted at the individual level, public health plays multiple roles in assuring the provision of services to those most in need and in encouraging changes to the health system that seek to orient public health and clinical settings towards addressing the upstream sources of illness and injury. Evidence suggests that population health strategies can and must be delivered in coordination with client level services for maximum health impact. By examining interventions in the context of these conceptual frameworks, public health and its partners can ensure the provision of complementary strategies that address the root causes of health issues while also assuring health care delivery to patients in need.

⁴¹ National Research Council. *The Future of the Public's Health in the 21st Century*. Washington, DC: The National Academies Press, 2002

Structure and Function of CDPHE

CDPHE, as the state-level public health entity, is responsible for aligning priorities and resources to improve and sustain public health and environmental quality. The Department is unique across the country in its structure as both the human health and environmental health agency in the state. Colorado has separate human services and Medicaid departments at the state level. CDPHE assures communicable disease prevention and control, health promotion and disease management, licensure for hospitals, nursing homes, and other health facilities as well as emergency medical services and preparedness. The environmental component of the agency oversees all water quality, food, and product safety as well as hazardous and solid waste.

Decades of public health work have demonstrated that the factors which affect health arise at various levels within the community and society and involve the physical environment, social and economic conditions, and individual behaviors and choices. CDPHE seeks to work across these different levels in order to target initiatives that ensure health and wellness for the general population.

CDPHE's Prevention Services Division (PSD) is actively involved in 9 of the 10 essential services shown in Figure 1, and supports the provision of service 7 – linking people to health services – through grants to local agencies. Thus, PSD plays a particularly germane role within Colorado's Innovation Model as it operates numerous programs that advance health promotion, improve wellness and prevention efforts across the health system, including promoting the integration of public health with primary care and behavioral health services.

In providing the 10 Essential Services and working to make Colorado the healthiest state, CDPHE is focusing on 10 Winnable Battles. These are 10 key public health and environmental issues where progress can be made in five years. These broad topic areas are being customized by regions, counties and cities based on local priorities and needs. The Winnable Battles are:

- Clean air
- Clean water
- Infectious disease prevention
- Injury prevention
- Mental health and substance abuse
- Obesity
- Oral health
- Safe food
- Tobacco
- Unintended pregnancy

Six of the ten Winnable Battles are based in the Prevention Services Division (PSD) and are especially germane to Colorado's vision of integrating public health with primary care and behavioral health services.

Structure and Function of LPHAs

Local public health agencies have the responsibility and authority to provide public health services to their communities across Colorado. State law requires that each of the 64 counties either maintain a public health agency or participate in a district (multi-county) health department. Most LPHAs exist as a department within a single county, and four district agencies serve a combined total of 17 counties. Other LPHA configurations exist in the form of a non-profit agency contracted to be the LPHA in a community, combined health and human services agencies, and as a multi-county arrangement without the formal district distinction. In many cases, especially in the rural areas, multiple LPHA jurisdictions are served by one regional behavioral health center.

LPHAs in Colorado are in the midst of a major transition brought on by the Colorado Public Health Act of 2008. This law, written by public health leaders, was a revision and modernization of previous public health laws that regulate the structure and function of LPHAs and activities of CDPHE. Since being codified in 2008, the LPHA system, guided by technical assistance, coordination and funding from CDPHE, has been the major impetus for the evolution of LPHAs. The main, relevant changes in law are the addition of minimum qualifications for a local public health director, the requirement that every LPHA jurisdiction perform a community-driven, community health assessment and develop a community health improvement plan, the development of a set of core public health services that every local public health agency must provide or assure the provision of in its jurisdiction, and a set of standards to which they must perform these activities. The state adopted the national, Public Health Accreditation Board (PHAB) standards as the state standards, recently. While the local public health system is in transition and LPHAs are evolving to meet their obligations under the law, there is not a strict enforcement process to defund agencies that do not yet perform all core services at the minimum standard. In addition to changes driven by the Act, a significant amount of leadership turnover, movement toward national voluntary accreditation, health reform, and ongoing budget cuts are causing LPHAs to re-think, reaffirm and restructure to best position themselves to have a positive impact in the community.

Colorado LPHAs required by state law to provide, or assure the provision of, the following core public health services:⁴²

- Assessment, planning, and communication
- Vital records and statistics
- Communicable disease prevention, investigation and control

⁴² Colorado Department of Public Health and Environment, State Board of Health, Core Public Health Services: 6 CCR 1014-7 (11/30/2011). <http://www.colorado.gov/cs/Satellite/CDPHE-Main/CBON/1251588259796>

- Prevention and population health promotion
- Emergency preparedness and response
- Environmental health
- Administration and governance

Within each of these core services, exists additional detail about the types of related activities and programming. While these are the minimum core services, most public health agencies perform additional, community-focused activities and initiatives. In terms of activities and initiatives, Colorado LPHAs mirror some of the national trends. The 2010 National Association of County and City Health Officials Profile of Local Public Health Departments shows the following activities as the most commonly provided by Colorado LPHAs:

- Child immunization provision
- Adult immunization provision
- Communicable/Infectious Disease Surveillance
- Tuberculosis Screening
- Population-based Nutrition Services
- Tobacco Prevention
- High Blood Pressure Screening
- Tuberculosis Treatment
- Maternal Child Health Home Visits
- Environmental Health Surveillance

In addition to population-focused prevention services, LPHAs provide numerous direct services—making them a critical component of the health care delivery system, particularly in underserved areas. As either a primary or “safety net” provider, LPHAs may offer direct services such as:

- Services for children with special health needs (including care coordination, pediatric clinics and development of medical homes)
- Immunizations
- Family planning services
- Nutritional support for women and children
- Nurse home visitor programs
- Disease screening and treatment (e.g., tuberculosis)
- Chronic disease self-management
- Oral health services

As the public health system moves forward in integration of public health and prevention with other health partners, it will be within the context of this ongoing evolution to provide core public health services and other activities as driven by community needs determined through the community health improvement planning process.

Local Public Health Agency Funding

Most LPHA funding comes from federal funds that flow through CDPHE and local funds, supplemented with state funds. Many of the state and federal flow-through funds come to LPHAs through competitive grant programs. Most LPHAs do not have a robust capacity to bill public or private payers for their work (although some LPHAs are now billing health plans for immunizations and other limited services) and frequently must tailor their service provision to the restrictions and requirements that accompany grant funding. When LPHAs are well connected to insurance payment and funding mechanisms to adequately support their direct services, they will be able to use grants and local funding to focus on population-based prevention work beyond their current scope.

Community Health Assessment and Planning

CDPHE’s Office of Planning and Partnerships is tasked with coordinating and providing technical assistance to LPHAs engaging in the required community health assessment and planning process. The process is required to have deliberate and ongoing community involvement and is intended to be an assessment and plan for the community, not just for the LPHA. All LPHAs are in some phase of the assessment and planning process, and many have worked with their community to select a few key health priorities that community member and leaders see as most important to tackle. The priorities selected by communities align with Colorado’s 10 Winnable Battles in a way that allows state and local leaders to determine statewide interest, need for support and potential system changes. The diagram below (Figure 4)

shows the various winnable battles that have been selected by each of the LPHAs across the state.

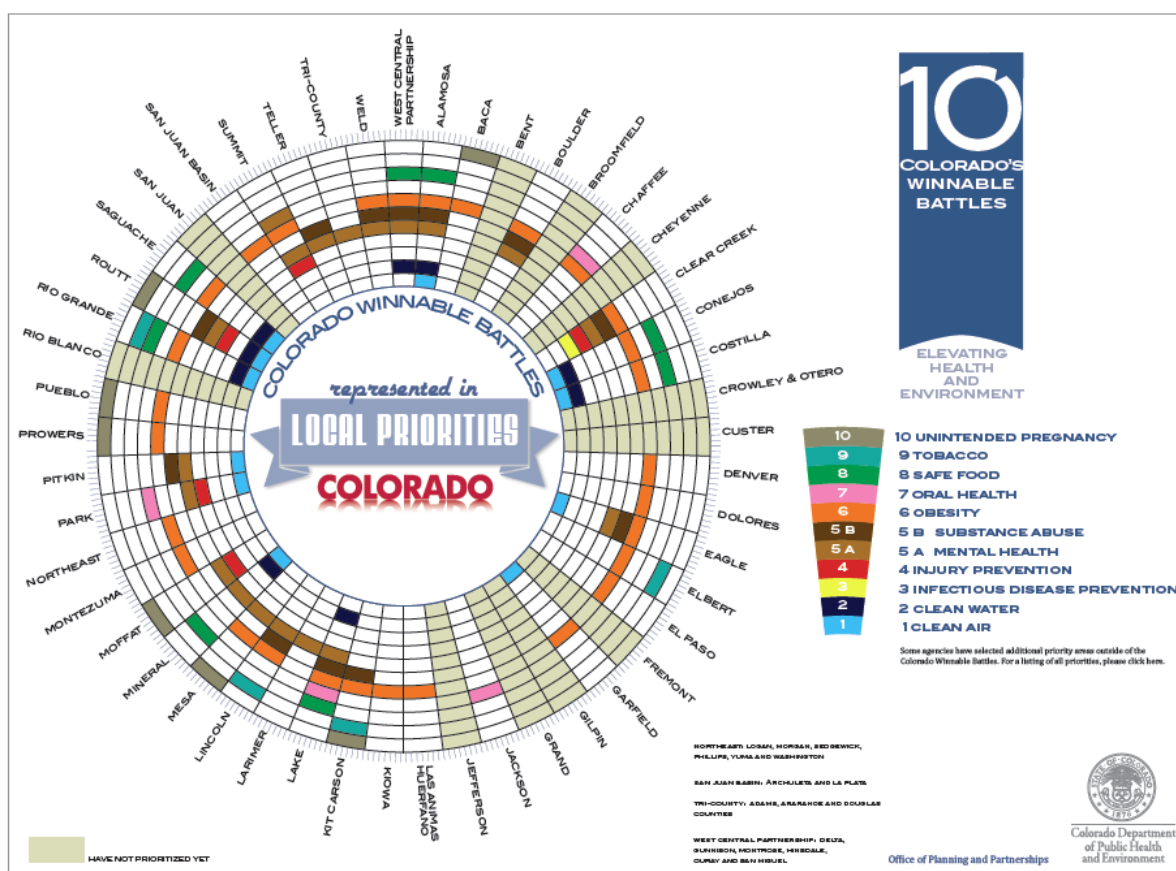


Figure 4: Priorities selected by local communities categorized by Winnable Battle area.

Source: Colorado Department of Public Health and Environment, Office of Planning and Partnerships, 2013

It is important that so many LPHAs and communities, independent of each other, selected mental health and substance abuse as two of the most important priorities. Being that LPHAs are not a primary provider of mental health services, these communities are planning activities and initiatives that are collaborations among local partners. Among the communities that have selected to focus on mental health and substance abuse, some of the more common selected interventions include increasing, ensuring or promoting the following areas: media, social marketing, and influencing perceptions (such as perceived risk); treatment and receipt of care; early detection, screening, referral; primary prevention and social support; collaborative, integrative care and treatment for co-occurring disorders; and data collection/surveillance and evaluation.

One of the biggest challenges moving forward is the lack of dedicated funding for LPHAs and communities to implement their community health improvement plans. LPHAs will continue to piece together various grants, donations and tax dollars to help their community reach its goals.

Community-based Organizations

We know that community-based organizations are critically important in public health,

especially in connecting with underserved communities. However, as organizations they are difficult to quantify because many of them serve several different purposes, may not be registered as a nonprofit, or may only exist for a short period of time. These organizations do not have a singular advocacy organization to help describe the system and their activities and initiatives. Examples of these community-based organizations include: the Chronic Care Collaborative that brings together 28 member organizations representing the one in four Coloradans who are living with chronic disease, and the Center for African American Health, which provides culturally-sensitive disease prevention and management programs to African-Americans living in the Denver area. Integration of public health should include

Information Exchange between Public Health and Clinical Delivery Systems

State and local public health agencies have limited connectivity to Colorado's HIE. Though much of the state's population data is compiled and analyzed by these departments, there is little uniform communication between individual facilities and the larger public health entities. The lack of communication means we are missing opportunities for more robust surveillance that could enable more carefully tailored population health strategies.

Both CDPHE and LPHAs monitor a wide variety of physical and behavioral health indicators and risk factors. Data is captured through reports from hospitals and clinicians, death certificates and public surveys. The initial focus for public health data transmission included electronic newborn screening orders and results delivery, electronic submissions of immunizations to the state registry (CIIS) from provider EHRs, and electronic submission of reportable conditions to the state registry (CEDRs).

As with other integration work in Colorado, there are individual examples from individual communities with little linkage and no common vision. This makes it challenging to directly connect the rich information in these public health databases with clinicians and health care facilities to inform their intervention strategies and help them meet Meaningful Use criteria. From the other side, it is also challenging to link clinical records into public health databases. For example, there are no standards for data extraction from EMR's, so data coming from clinicians varies from one system to another. Behavioral health providers have different EMR capabilities, plus there are privacy and release of information policies required for sensitive information, and misunderstanding around the requirements of the privacy laws. As a result of the disconnection between public health and clinical data, we are missing opportunities for more robust surveillance that can enable more carefully tailored population health strategies.

CDPHE is working with the Colorado Regional Health Information Organization CORHIO, Colorado's State Designated Entity (SDE) for health information exchange (HIE), Quality Health Network, the HIE covering the western part of the state, and some local public health agencies to begin connecting these disparate components. CORHIO and CDPHE have identified providers and hospitals to begin pilots reporting public health data from statewide clinical records services. These projects will facilitate electronic reporting of communicable diseases, cancer cases, and immunization records to CDPHE.

Workforce

The public health workforce in Colorado is evolving as much as the system itself. Prior to the development of the Colorado School of Public Health, accredited in 2010, the Rocky Mountain region lacked a comprehensive school of public health. The new school of public health is offering degree-granting and professional development opportunities for professionals in the workforce and developing newly trained professionals. In addition, two undergraduate programs in public health have also opened in the state.

While we know there is an increase in Master's prepared public health professionals based on graduation from CSPH, the current public health workforce is difficult to enumerate. This is not just a Colorado issue. A recent American Public Health Association issue brief⁴³ stated "Due to its diversity and range of settings, and the absence of funding for enumeration efforts, the exact size and composition of the public health workforce remain uncertain." Researchers in public health systems are continuing to test new methods and explore enumeration of the public health workforce, but for the time being, we must estimate.

Along with growing national efforts, Colorado has some limited information on its public health workforce from the NACCHO Profile, ASTHO Profile, and state level data collection. In 2011, more than 2,700 people were employed in Colorado local public health agencies across every Colorado county. Approximately 22% of the workers are public health nurses, 26% are administrative and clerical staff, 17% are environmental health professionals and 6% are health educators⁴⁴. The state health department employs more than 1,200 full-time equivalents⁴⁵. Because public health professionals are employed in such a wide variety of venues, it is difficult to estimate the full complement of professionals in Colorado.

While most LPHAs do not provide direct mental health services, 30 agencies employ health educators who are trained and skilled in theories of behavior change and interventions to change behavior at the individual, family, community and policy levels (NACCHO, 2010). These health educators work in a variety of topic areas, often based on funding, but have a core set of skills that can translate to any health-related behavior.

In addition to the evolving workforce in governmental public health, Colorado has been exploring the use of community health workers, patient navigators and other similar individuals to provide more appropriate and tailored assistance to patients. In late 2011, The Colorado Trust convened a workgroup to begin working to define the roles of community health workers and patient navigators, establish core competencies and licensing requirements, and identify reimbursement methods and sustainable funding for these health workers.

⁴³ The Affordable Care Act's Public Health Workforce Provisions: Opportunities and Challenges. American Public Health Association, 2011

⁴⁴ National Association of County and City Health Officials National Profile of Local Health Departments, 2010

⁴⁵ Association of State and Territorial Health Officials Profile of State Public Health (2010).

According to a recent survey by the Colorado Community Health Workers/Patient Navigator Workgroup⁴⁶:

- Less than 25% of CHW/PN work in public health settings, the majority work in non-clinical community settings.
- Over 70% of CHW/PN see their primary role as a link between clinical services and community resources for patients.
- Less than 20% of CHW/PN are reimbursed through public or private insurance or other permanent funding source. The remaining 80%+ are grant funded or volunteers.
- 40% of CHW/PNs have had no formal training in their role.

The CHW/PN Workgroup has worked over the past year to develop a set of competencies that takes into account the roles that CHW/PNs have been filling and how they are being used within existing health systems and LPHAs (see Appendix). Establishing core competencies is the first step towards developing a consistent training curriculum for CHW/PNs.

Community colleges have already started offering formal CHW and PN training: the Community College of Denver is currently running a training program for CHW and has included that training in their new Master of Social Work degree, and Otero Community College has a program to train patient navigators. It's unclear whether these training programs cover the competencies the group at The Colorado Trust have identified or if they will lead to funded and reimbursable positions after completion of the program. However, it is clear that Colorado is moving forward in developing a workforce that can meet the needs of communities.

Federally Funded Initiatives

Colorado communities benefit from numerous federal public health programming investments at the state and local levels. (see Appendix for a selected listing of current federal grant-funded programs in the public health arena). In 2009, CDPHE reported that 46 percent of its funding is from federal sources. Approximately 30% of the total funding for local public health agencies comes from federal sources (direct or pass-through state). In addition, Colorado has a history of leveraging federal dollars into state and local investments.

- *The CDC Communities Putting Prevention to Work (CPPW) program in Colorado - Peak Wellness Program (Tri-County Health Dept. - Adams, Arapahoe and Douglas counties)*
This program blends multiple screening programs supported by diverse state and federal funding sources into a comprehensive wellness package for low-income, uninsured, and under-insured women ages 40-64.
- The Colorado Oral Health Surveillance System (COHSS) monitors the burden of oral disease among Coloradans by collecting, analyzing, and disseminating data to inform and support oral health decision-makers in Colorado.
- Colorado's National Public Health Improvement Initiative (NPHII) funding has been used to support local public health agencies with data collection and technical assistance

⁴⁶ Add cite from workgroup

for community health assessments. This work has fed into the creation of a statewide health assessment that will be used for the next public health improvement plan for the state. The funding has also been used to support a number of quality improvement efforts, such as fiscal and contract management streamlining with LPHA's, data standardization for food safety and a strategic plan for CDPHE. A current goal for this funding is to prepare CDPHE for PHAB accreditation.

Public/Private Partnerships

Colorado has worked to develop partnerships between public health and private insurers, such as:

- *The Colorado Prevention Alliance (CPA)*—a collaboration among state and local public health agencies, Medicaid, private health insurers, providers and purchasers—has created a forum to work together toward population health goals such as smoking cessation, immunization and diabetes prevention.
- *Immunization services* – With the regulation change in the use of the Vaccines for Children 317 funds, Colorado was a pilot site to develop alternative payment systems for local public health agencies. Initial tracking estimated that 20 percent of immunization patients had some type of private coverage. Multiple local public health agencies were successful in contracting with private payers, using a state-developed contract template.

Current Innovations

Colorado's emphasis on local priority setting versus a statewide uniform approach supports an environment that encourages local innovations. These innovations act like pilot programs, allowing us to see the effectiveness of a certain approach on local priorities. Many local initiatives have the potential to help transform health care delivery statewide. In addition to program-level work, Colorado is also involved in public health systems and services research that can help investigate, inform and guide how these innovations are implemented. We can't describe every program in the state, but there are several strong examples that demonstrate the power of local collaboration and innovation to transform population health and care delivery.

Northwest Colorado Community Health Partnership (NCCHP) Community Care Team (CCT)

Each member of the CCT (e.g., local public health agency, federally qualified health center, community mental health center, community service provider, etc.) encounters clients at different stages on the care continuum and can assist or refer them to the appropriate team member. Key elements include:

- Integrated Behavioral Health and Primary Care in federally qualified health center and private primary care practices, using resources from community mental health center and Northwest Colorado Visiting Nurse Association
- Care Coordination Services for Medicaid clients, providing both primary and behavioral health care coordination
- Outreach and Prevention, specifically focused on tobacco cessation, cardiovascular health, and patient navigation

North Colorado Health Alliance (NCHA) Established in 2002, NCHA is a community joint venture that brings together public and private health care providers (primary care, behavioral health, hospital, etc.) with the local public health agency, county commissioners, paramedics and community service providers. The goal of the NCHA is a healthy population with 100 percent access to high quality care at an affordable reduced cost, with a special emphasis on the underserved. Key initiatives include:

- Make Today Count! Community health campaign
- Project LAUNCH, a SAMHSA grant program, to promote the physical and mental wellness of young children birth to age eight
- Care management for two Medicaid Regional Care Coordination Organizations

Mental Health First Aid (MHFA) MHFA is an evidence-based training program to help citizens identify mental health and substance abuse problems, connect individuals to care, and safely de-escalate crisis situations, when needed. MHFA helps to prevent the onset and reduce the progression of mental health and substance use disorders while promoting acceptance, dignity and social inclusion of people experiencing behavioral health problems. Key accomplishments include:

- In conjunction with the Colorado Behavioral Healthcare Council (CBHC), MHFA has grown from a handful of partners focused in the Denver-metro area to include a statewide network of 230 instructors that have certified nearly 10,000 Coloradans as Mental Health First Aiders to date
- CBHC is partnering with the Colorado Office of Behavioral Health to build up the infrastructure and implementation supports to take MHFA to scale statewide, including various objectives related to marketing, dissemination, evaluation and growth of the MHFA program

Practice-Based Public Health System Research: Multi-state investigation of primary care and public health integration – The Colorado Public Health Practice-Based Research Network, housed at the Colorado Association of Local Public Health Officials, is part of a new public health services and systems research project funded by the Robert Wood Johnson Foundation. The goal of the project is to examine variation in the degree of primary care and public health integration across local jurisdictions, identify factors that may contribute to or impede integration, and assess whether areas of increased integration have better health outcomes. Colorado joins Minnesota, Wisconsin and Washington in this multi-state research project that will produce publishable research findings as well as practical tools for local communities interested in integration.

Current Health Outcome Performance and Evaluation

CDPHE maintains the Colorado Health Indicators for the state. The current set of indicators were selected through a collaborative process among public health professionals in 2011. They include

county, regional and state level data on a variety of health, environmental and social topics. These data are used in Colorado’s Health Assessment and Planning System (CHAPS), the standard process created to help local public health agencies meet assessment and planning requirements from the Public Health Act of 2008. These indicators are useful for anyone who needs Colorado health data for a community health assessment or for other research purposes. The indicators are organized based on the Health Equity Model (see figure _), which takes into account a wide range of factors that influence health. This model groups the social determinants of health into:

- **Life course perspective:** how populations are impacted differently during the various stages of life
- **Social determinants of health:** societal influence, such as economic opportunity, physical environment and social factors that play critical roles in the length and quality of life
- **Health factors:** components of health behaviors and conditions, mental health and access, utilization and quality of health care
- **Population health outcomes:** measures of quality of life, morbidity, mortality and life expectancy

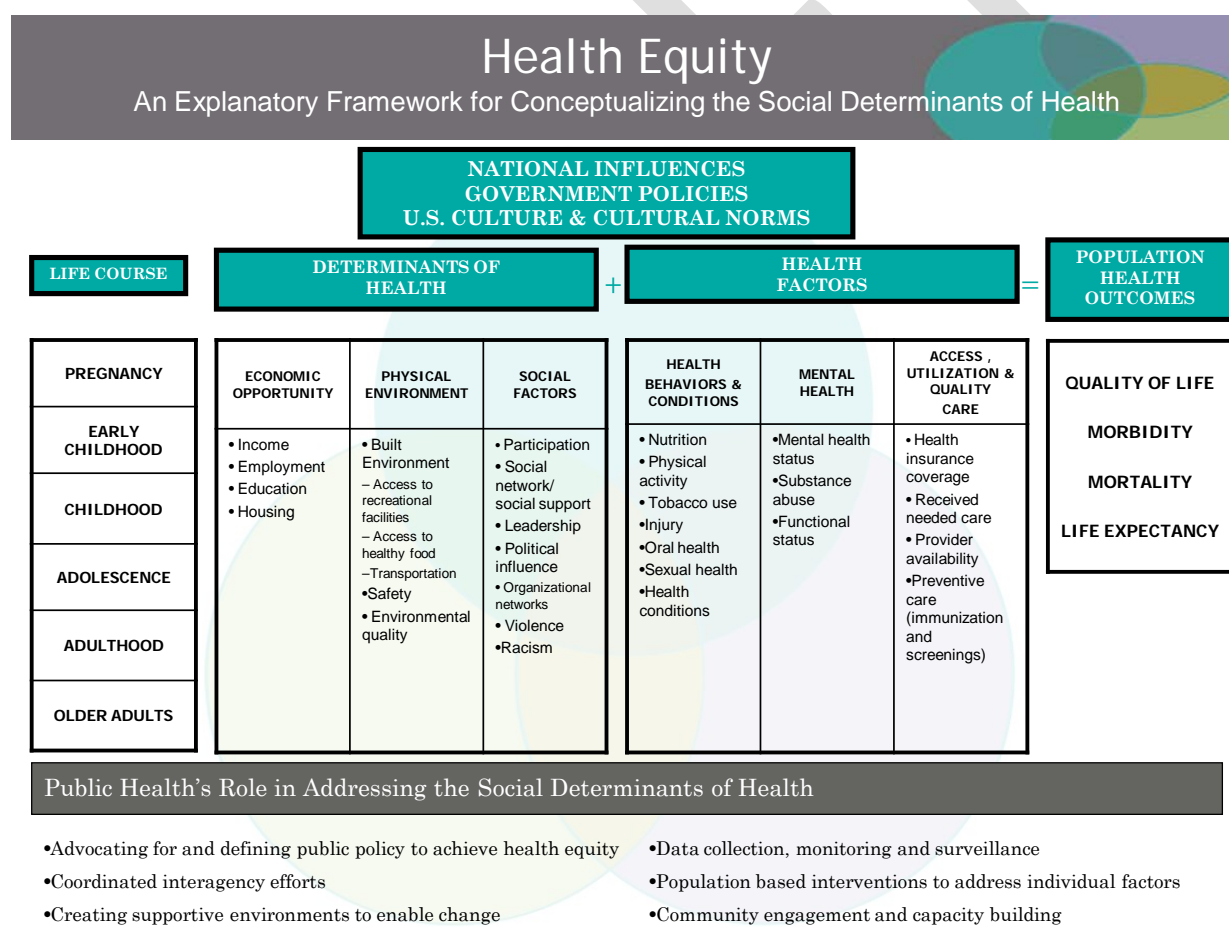


Figure:

Source: Colorado Department of Public Health and Environment

The Health Equity Model is a framework through which we can conceptualize a variety of interventions at the policy, community and individual levels. CDPHE and LPHA use of the Health Equity Model sets the stage for these interventions to have an impact on the root causes of poor health.

The data that populate the Colorado Health Indicators are provided by local, state and national sources and are updated on a regular basis. They are designed to help communities determine what issues need to be addressed at the local level as well as give a picture of the state's progress in certain areas.

The health indicators also align with Colorado's 10 Winnable Battles that were listed at the beginning of this chapter. Colorado's 10 Winnable Battles are public health and environmental priorities with large-scale impact on health and the environment, and with known, effective strategies to address them. By measuring the health outcomes, environmental improvement and other strategies associated with each appropriate Winnable Battle, we will know where progress has been made and where more needs to be done. Each of the Winnable Battles has a target to be attained by __ and is associated with a number of individual metrics that give a picture of the progress being made on that topic (see table __).

The LPHAs also work with the Winnable Battle framework, selecting the individual measures that are most critical for their area in order to align with the state priorities (see Figure __, p.__). It is important to note, though, that local public health agencies and community-led health initiatives (such as those described earlier in this document) focus on the population health priorities and metrics that make most sense for their communities and on which they believe they can deliver short-term results. This structured independence approach allows communities to target efforts and resources on the issues that are most important to their community while still contributing to the overall goals of the state.

Colorado is similar to many other states with both urban and rural/frontier areas. This geography and the small population size in rural areas can present difficulties in this type of population data. CDPHE has outlined data and statistics regions that allow for the reporting of regional data where county level sample size is too small. CDPHE is working with some rural local public health agencies on community-based data collection and analysis to help overcome some of these issues.

In addition to these two consolidated sets of measures, the state's public health entities are responsible for the ongoing data reporting and monitoring of many national surveillance programs run through agencies like the Centers for Disease Control and Prevention. Some of these surveillance system measures also contribute to the state evaluation metrics.

A Vision for the Future

In Colorado, the integration of public health with mental, physical and behavioral health systems will require work on a number of different fronts. Aligning the efforts of CDPHE, LPHAs, and community-based efforts will be a critical first step towards creating a cohesive system to support population health across the state. We need to leverage the power of these local public health innovations to enhance the delivery of physical and behavioral health care. These efforts

across the state are an excellent way to address community health needs, but we need to ensure that local efforts are driving towards overall state goals to have a system-wide impact.

In order to begin developing solutions to these challenges, the Public Health Workgroup decided to ground its thinking in a population-based health framework where solutions to health problems are directed toward changing systems, policies and environments in order to alter norms and behaviors for the entire population. The focus in a population-based approach is on changing systems and policies with the potential to create sustainable impact in the greatest number of people. Evidence-based or evidence-informed practices and programs are used as much as possible and primary prevention (i.e., preventing health issues in susceptible populations) is given priority. Partnering with representatives of the population is also essential in assessment, planning, and implementation of population-based solutions.

Population health in the context of integrated care can be envisioned as a continuum of care progressing from a clinic-based coordination model to a comprehensive, prevention-focused model that goes beyond clinical care to keep the population healthy⁴⁷:

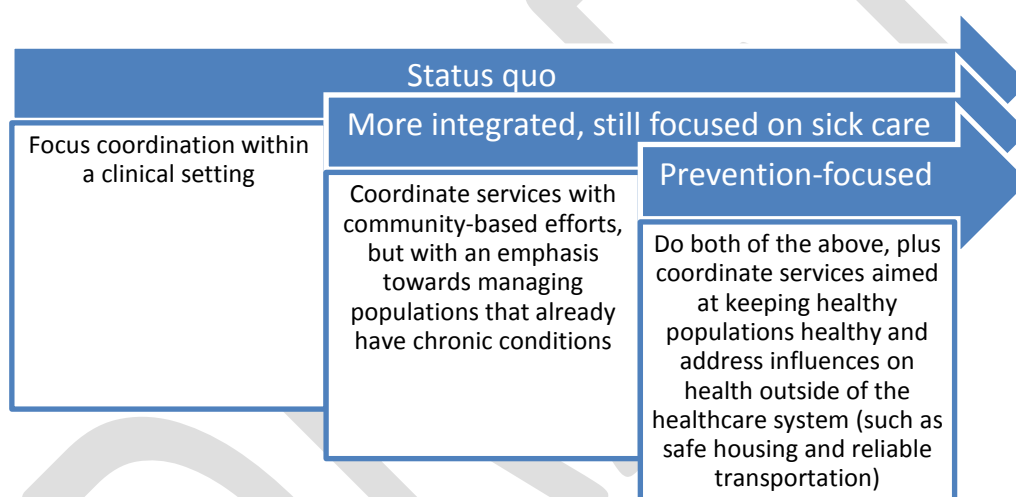


Figure:

Source:

Colorado wants to focus its efforts to integrate clinical care delivery (physical, mental and behavioral) with population health on the prevention-focused end of the continuum.

Many of the aforementioned processes and documents that describe the current state of health in Colorado, also have a vision, description of a preferred state, or recommended plan of action. The SIM public health workgroup was charged with creating a goal that will lead to the integration of public health, prevention and population health with the health care system. The workgroup deliberately created a broad goal that can be aligned with the multitude of other visions and goals related to the integration of public health, prevention and population health with the health care system. It is also a goal that other entities, such as the professional associations that represent public health, primary care and others, can complement with their

⁴⁷ Adapted from information provided by National Governors Association, July 9, 2013.

own more detailed goals and strategies. The alignment of goals and strategies will result in continued dialogue among partners.

A 2012 report from the Institute of Medicine (IOM), “*Primary Care and Public Health: Exploring Integration to Improve Population Health.*” noted that “most efforts to integrate care delivery and improvement in primary care and public health are locally led and defined, and there are very few examples of successful integration on a larger scale.”⁴⁸ Therefore, Colorado’s goal for integration is to:

Create a statewide infrastructure to support and coordinate community-driven solutions to population health needs within a framework of common statewide goals and metrics.

This goal reflects the robust foundation of community-driven initiatives around the state that already exist to promote population health. We propose to build on that strong foundation, recognizing that much of health care is local. At the same time, though, we must ensure that every community in our state is pulling in the same direction and has access to resources to support its efforts. We have accomplished this kind of coordination in limited ways before, but now it’s essential to scale our previous efforts and work together to create common goals and a statewide framework.

Attaining the Vision

In order to create a system of truly integrated public health, health care and behavioral health, we have to establish the system to support it. We have described the way in which Colorado communities have developed innovative local approaches. Our challenge now, is to leverage and interlink those efforts and to provide a statewide vision and system of support. The obstacles identified by the workgroup are far from the only things that need to happen in public health across Colorado, but they were common themes that can be addressed to move us down the path towards an integrated, supported approach to population health. As potential solutions to these issues, stakeholders identified programs and solutions already on the ground or in development that could be scaled and used as a starting point for public health innovation in Colorado. We must continue the momentum of this workgroup and the innovation planning process by engaging additional partners in the ongoing visioning and working toward specific goals.

1. Health Extension Service

Colorado has begun to develop a “Health Extension System” (HES) that supports and broadens the work of community/regional health alliances by bringing additional resources to the community, fostering linkages with new/different participants, and coordinating local and state health improvement initiatives.

⁴⁸National Academies of Sciences (2012). Primary Care and Public Health: Exploring Integration to Improve Population Health: 2-14. http://nap.edu/catalog.php?record_id=13381

The HES originates in the concept of a Primary Care Extension Service funded through the Section 5403 of the Patient Protection and Affordable Care Act . That section of the law created a mechanism, modeled on the agricultural extension service, for connecting primary care practices (especially in rural areas) with tools and resources that would help them transform into patient-centered medical homes. Colorado received a small amount of seed funding to plan its extension service as a “dissemination state” for Oklahoma’s extension service.

Colorado’s approach to extension is broader than the original vision in PPACA. While supporting primary care transformation is still a key component, the organizations developing Colorado’s approach (including the University of Colorado, Center for Improving Value in Health Care, HealthTeamWorks, CDPHE and others) have identified a need to link primary care practices more closely with community health improvement efforts, and an opportunity to link those community initiatives with additional statewide resources (e.g., universities, state health department, etc.).

The HES can be thought of as a general contractor or director that supports the alignment of existing services and helps to direct individuals, practices and services to the resources available in the state. The primary goals of the HES would be to:

- Assist primary care
- Facilitate practice transformation
- Collaborate with community partners
- Identify local workforce needs
- Address social and primary determinants of health

The HES would not supplant existing coordinating organizations such as the Network of Community Health Alliances or the Colo. Assn. of Local Public Health Officials. Rather, it would be a statewide hub to connect these organizations, and the groups they serve, with each other and with additional resources to execute the goal statement above. The Extension Service would also be a means by which to inform statewide research and planning “from the bottom up” through its on-the-ground relationships with local initiatives. For example, the Extension System could:

- Connect primary care practices with community health improvement efforts as part of practice transformation support and advancing a shared vision of population health.
- Train primary care practices on how to use community health workers and collaborate effectively with community service providers, local public health agencies and other organizations.
- Bolster local health alliances by linking them with private primary care practices and statewide resources such as the Colorado Clinical Translational Science Institute, an NIH-funded initiative that connects community organizations with university- and hospital-sponsored research to accelerate improvements in population health.

- Help LPHAs and local hospitals execute their community health improvement plans by connecting them with primary care practices and university resources.
- Link communities with resources/common curriculum for training community health workers, and best practices for deploying these workers for primary prevention initiatives.
- Establish common measures to assess both the impact of interventions (“did it work?”) and their structure (“why did it work?”) to identify strategies that can be exported to other communities.
- Act as a resource center for providers and community organizations seeking partners and resources, fielding requests and facilitating linkages.

With the support and resources coming from the HES, LPHAs would be better equipped to coordinate with other local care providers to create solutions to the community’s identified health priorities and contribute to the overall health of the state.

2. Connecting Public Health with the Clinical and Behavioral Health IT Systems

Successfully integrating the structure of public health into the clinical delivery system will depend on communication and coordination between the different elements of the system – data collection and evaluation are critical to demonstrating the opportunities, challenges and overall success of the system. For example, the connections between clinical care and public health planning and service delivery will enable:

- Using epidemiological data to identify care priorities and target health promotion/disease prevention efforts at a clinical level.
- Adding chronic mental illness to epidemiological reporting to develop a better understanding of the population dealing with chronic mental illness and how they interact with the clinical care and behavioral health delivery system.
- Incorporating behavioral health priorities and outcomes targets into public health planning for more comprehensive, whole person approaches to population health.

In order to integrate the public health system with the clinical delivery system, public health must also link into the HIE. Currently, several statewide public health surveys are collected by CDPHE and shared with LPHAs (i.e., the ARIES program tracking data on alcohol and drug abuse within HIV populations or the Colorado Immunization Information System (CIIS) that provides consolidated immunization information). These programs are designed to support public health initiatives, and are not typically designed to be reported back to physical and behavioral health providers. Likewise, there are data collection requirements that feed essential outcomes data back to clinicians through the EMR, but are not shared or exported to the state or local public health agencies.

The benefits of integrating public health into the HIE include:

- Connecting population health records to clinical data systems to support evaluation, surveillance and priority setting at a community level as well as statewide.

- Interconnecting all health data systems in order to provide whole person care. CORHIO has already been working with CDPHE to build interoperability for public health data transmission and collection important to the meeting Meaningful Use requirements and serving overall population health.
- Working with communities and regional alliances to create interoperability and the health information infrastructure to support the integration of physical, mental, behavioral and public health. This is already being developed by the Public Health Information Exchange Steering Committee (PH HIE), in coordination with CORHIO and QHN.

3. Reimbursement

Currently, public health receives much of its funding through unsustainable, project-based grants. Even when public health is able to bill insurers for specific services, the reimbursement for service provision in a public health setting is substantially lower than the reimbursement would be in a traditional care delivery setting.

We must expand the use of reimbursement mechanisms that enable the public health system to become a part of accountable care organizations (ACOs) and to contract directly with private payers. As the focus of the health care system moves toward prevention and population health, public health agencies are ideally positioned to help both Medicaid and commercial health plans meet these goals in a high-quality, cost-effective fashion. But LPHAs should not be expected to provide these services solely through their existing government and grant funding sources. Rather, as Medicaid and commercial payers develop clinical ACOs in partnership with hospitals and primary care providers, they should explore ways to bring LPHAs into those contracts for preventive care services. In addition, expanded use of and reimbursement for community health workers will help Colorado achieve its population health goals.

4. Workforce

In order to be successful in our integration efforts, we need the workforce to support the new infrastructure. Colorado must create a comprehensive health workforce development and training strategy in that includes both “supply” (i.e., academic institutions) and “demand” (i.e., communities, clinics, hospitals) perspectives by mapping the supply against population health priorities and community health needs to estimate anticipated workforce needs. While there have been several high-quality studies of the existing workforce in Colorado, those studies have focused on the traditional health service provider workforce of doctors, nurses, and medical assistants, not on the needs of the public health workforce. There are, however, many existing sources of data around the state that can contribute to the public health mapping process:

- Department of Regulatory Agencies database of licensed professionals
- The Colorado Health Institute’s workforce maps
- Profile of Local Health Departments from the National Association of County and City Health Officials (NACCHO)

- CDPHE and CALPHO data collection on the structure, funding and staffing of local public health agencies
- The Colorado Community Health Worker/Patient Navigation Survey, supported by The Colorado Trust

Each of these databases contains critical information for determining Colorado's existing public health workforce and its distribution, but they are housed in different locations, making it very difficult to paint a comprehensive picture of Colorado's needs. By combining the available databases, we will be able to evaluate exactly what kinds of health care and public health workers are needed and where the need is most severe. Colorado should participate in national efforts in defining and enumerating the public health workforce and quantifying workforce needs, with focused resources, this can be accomplished through the Colorado Public Health Practice-Based Research Network.

With our growing school of public health, additional dual degree programs, and undergraduate programs in public health, as well as efforts to prepare health care students with a multi-disciplinary view, our highly-trained public health professional workforce will continue to increase. An integrated system must continue to find the best ways to utilize these individuals throughout, not just in traditional public health organizations.

The Role of Community Health Workers and Patient Navigators: In addition to looking at what supply will be required, we need to look at the training programs available. We know that we have a shortage of non-professional public health staff that could be an affordable way to provide educational services and basic community-public health connections. Therefore, the development and promotion of community health workers and patient navigators is critical to the successful integration of public health into physical and behavioral health.

These community health workers will be able to:

- Bridge the gap between clinical and population health.
- Focus on community resources and transitional care so physicians can focus more exclusively on direct care provision.
- Decrease costs by allowing us to designate appropriate work force to appropriate tasks.

Colorado already has a growing number of community health workers and patient navigators, but the competencies of these positions have not yet been defined in a concrete way that will allow these roles to be built into the public health infrastructure.

The work of the CHW/PN Workgroup will be a critical platform to use to develop the pool of skilled workers that will be needed to effectively integrate public health into the larger health care delivery model. Once these competencies are accepted and a certification program is developed, these new staff positions will be able to become an integral part of the health care workforce. Their focus on community relationships and navigation will free up the time and expertise of our public health and health care professionals, allowing them to more efficiently spend their time on activities that truly require their extensive training and expertise.

Policy and Regulatory Changes Needed

Evaluation

Earlier this year, representatives from CDPHE, the Department of Health Care Policy and Financing (HCPF) and the Department of Human Services (CDHS) joined forces to examine the current evaluation measures used by the three departments. Many of the measures used internally by these groups and publically throughout the state are duplicative or not in clear alignment with the rest of the state. This group hoped to create a Tri-agency Collaborative Data Set that would ensure a highly effective, efficient, and elegant service system infrastructure to further integrated health care service and improve behavioral health care in the State of Colorado. This data set will combine the critical measures from all three departments and align them with the state's goals to minimize duplication and streamline the evaluation of public health across the state.

This data set will combine the Governor's State of Health Goals, the Colorado Winnable Battles and essential measures from each of the departments and place them in a framework that emphasizes the social determinants of health. The determinants of health are those resources necessary for achieving good health, such as access to safe food, water, and housing. Underlying these factors is the need for quality education and jobs that pay a living wage. Poverty is a strong predictor of poor health. Health behaviors also play a role in determining health outcomes.

Colorado will be using the Social Genome Model from The Brookings Institution's Center on Children and Families. The initial model structured around social mobility over the life cycle and

has identified key goals at each stage across the developmental continuum that contribute to attainment of “ensuring that as many individuals as possible are middle class by middle age.” (Brookings Institute; The Social Genome Project: Mapping Pathways to the Middle Class; April 2013) This model aligns with the Health Equity Model already used in governmental public health. Utilizing the Social Genome Model as a framework for social mobility and collectively reporting on aligned measures on a statewide basis will allow for enhanced information for policy and decision making, and analysis for interventions impacting population health.

Conclusion

Colorado’s public health and health care systems are at a crucial point in their evolution. If these systems continue the status quo and evolve in parallel we will be unable to meet our goal of being the healthiest state, but more importantly, we will never be able to reach a state of health equality. To truly make a positive impact on the health of Coloradans, we must create a more connected, supported and unified *health* system. These systems have the opportunity to evolve in a way that builds this interconnectedness across the state. We must leverage the potential of population-based prevention through the public health system and connect it with the health care and behavioral health systems through data, funding, multi-disciplinary professionals and community engagement. We are not starting from scratch in this effort. Colorado communities have been leading the way with a wide variety of innovations that can be considered pilots to be scaled up across the state. First, we must build the system foundation upon which these pilots will be supported and sustained. With a collaborative approach that uses Colorado’s strengths, is clear about our challenges and gaps, and builds on what we already have created, we can set out toward a better future of health in Colorado.

Public Health Workgroup Members

Lisa VanRaemdonck, Chair	Executive Director – Colo. Assn. of Local Public Health Officials
Bernadette Albanese, MD, MPH	Boulder County Dept. of Public Health
Lauren Ambrozic	Colorado Prevention Alliance
Jackie Brown	Southeast Mental Health Services
Bill Burman, MD, MPH	Director, Denver Dept. of Public Health
David Goff	Dean, Colorado School of Public Health
Chris Habgood	Colorado Office of Behavioral Health
Gretchen Hammer	Colorado Coalition for the Medically Underserved
Camille Harding	Colorado Dept. of Health Care Policy & Financing
Jim Hill, MD, MPH	University of Colorado School of Medicine
Peggy Hill	Colorado Behavioral Health Council
Tom Hill	Colorado Hospital Assn.
Jillian Jacobellis	Colorado Dept. of Public Health & Environment
Dawn Joyce	Colorado Dept. of Public Health & Environment
Gabriel Kaplan	Colorado Dept. of Public Health & Environment
Kate Kiefert	Colorado Regional Health Information Organization
Mindy Klowden	Jefferson Center for Mental Health
Kern Low, MD	Colorado Academy of Family Physicians
Jennifer Ludwig	Eagle County Dept. of Public Health
Barbara Martin	University of Colorado Dept. of Family Medicine
Dayna Matthew	University of Colorado School of Law/School of Public Health
Karin McGowan	Acting Director, Colorado Dept. of Public Health & Environment
Sara Miller	Colorado Foundation for Public Health & Environment
Sharon O'Hara	MS Society/Chronic Care Collaborative
Ben Price	Colorado Association of Health Plans
Jessica Sanchez	Colorado Community Health Network
Sara Schmitt	Colorado Health Institute
Chet Seward	Colorado Medical Society
Karen Trierwiler	Colorado Dept. of Public Health & Environment
Judy Zerzan, MD	Colorado Dept. of Health Care Policy & Financing

DRAFT

Key Elements Necessary for an Integrated Primary Care Practice:

1. A multidisciplinary practice team tailored to the needs of each patient and situation
 - A. With a suitable range of behavioral health (BH) and primary care (PC) expertise and role functions available to draw from
 - B. With shared operations, workflows and practice culture to support the practice team in providing integrated patient-centered care and to ensure collaboration
 - C. Having had formal or on-the-job training in preparation for the clinical roles and relationships of collaborative care, including but not limited to culture and team-building
2. A shared population and mission
 - A panel of patients in common (shared across medical and behavioral health providers) for total health outcomes (behavioral & physical)
3. Systematic Clinical Approach with systems that enable it to function
 - A. Patient identification: Employing methods to identify those members of the population who need or may benefit from BH integration
 - B. Patient engagement: Engaging patients and families in identifying their needs for care and particular clinicians to provide it;
 - C. Shared care plan: Using an explicit, unified and shared care plan (one unified plan, rather than separate medical and behavioral health care plans)
 - D. Shared electronic record: The unified care plan and manner of support to patient and family in a shared electronic health record
 - E. Systematic follow-up & adjustment of treatment plans if patients are not improving as expected

Organizational and System Functions to Support an Integrated Primary Care Practice:

1. Reliable clinic operational systems and processes
2. Alignment of purposes, incentives, leadership
3. A sustainable business model (financial model) that supports the consistent delivery of collaborative, coordinated behavioral and medical services in a single setting or practice relationship.
4. Continuous QI and measurement of effectiveness;
 - a. Routinely collecting and using practice-based data to improve patient outcomes
 - b. Periodically examining and reporting outcomes
5. A community, population, or individuals expecting that behavioral health and primary care will be integrated as a standard of care

Scopes of Integration based on a Practice's Patient Population

Scope 1: Comprehensive primary care that includes the capacity to identify and treat patients with Mental Health (MH) and unhealthy substance use conditions within the scope of primary care that can be understood and treated more or less independently of other health conditions.

- This may include but not limited to anxiety, depression, PTSD, ADHD, risky drinking or drug use, family disturbance or other conditions commonly addressed in primary care.
- This does not include serious mental illness (SMI) or specialty mental health services such as intensive outpatient treatment or other specialized services.

Scope 2: Comprehensive primary care that includes the capacity to identify and treat patients with MH and unhealthy substance use conditions **PLUS** BH contributors to common chronic illnesses and MH/SA conditions deeply intertwined with chronic illnesses

- May include but not limited to major depression in a person with poorly regulated diabetes who considers diabetes their main health issue, stress-linked physical symptoms or psychophysiologic reactions or symptoms without medical explanation (headaches, stomach aches, pain, fatigue, etc.)
- Support to make health behavior changes to manage chronic illnesses or prevent medical conditions. May involve health-promoting or prevention behaviors such as realistic goal-setting, stress management, exercise, good nutrition, appropriate preventive services (e.g. breast cancer screening, immunizations)

Key Elements of Integration by Scope

Performance expected within each scope of integration:

- Care of individuals and clinic population or panel (population management, not only individual management)
- Acute, chronic, preventive aspects of care for each patient
- A threshold level of operational performance on required functions
- Identify social and care system factors that interfere with usual care and capacity to link patients to the appropriate community resources

Element 1: Team

A practice team tailored to the needs of each patient and situation

A. With a suitable range of BH and PC expertise and role functions available to draw from

Scope One

A. The practice has a multidisciplinary team that includes a behavioral health provider (BHP; or multiple BHPs onsite depending on practice size and needs) integrated as a member of the team to provide direct care as well as supervise BH services provided by other team members.. The BHP and practice team should have the suitable range of expertise required to fulfill the following roles/functions:**

- Triage, assessment for MH/SA conditions (e.g. ADHD, depression, PTSD or anxiety in an otherwise healthy adolescent or adult)
- Straightforward psychological/MH/SA treatments
- Behavioral activation/self-management interventions
- Health behavior change interventions to manage or prevent

Scope Two

A. The practice has a multidisciplinary team that includes a behavioral health provider (BHP; or multiple BHPs onsite depending on practice size and needs) integrated as a member of the team to provide direct care as well as supervise BH services provided by other team members. The BHP and practice team should have the suitable range of expertise required to fulfill the following roles/functions

- Triage, assessment for BH factors in common chronic illnesses (e.g. depression in cardiovascular disease or diabetes)
- Capacity to team with chronic illness care coordinators, PCPs and utilize information tools such as registries

<p>MH/SA conditions and alter unhealthy lifestyles</p> <ul style="list-style-type: none"> • Access to psychopharmacology assessments / treatment either onsite or offsite with close collaboration between providers • Follow-up care for identified MH/SA needs, monitoring of outcomes and care processes • Timely adjustment of care and coordination • Social support and family interventions for MH/SA conditions, including connections to community resources. • Crisis intervention and effective connection to offsite MH/SA specialists 	<ul style="list-style-type: none"> • Select and deliver or coordinate the BH interventions needed • Patient education / coaching in managing BH factors in chronic care • Health behavior change interventions to alter unhealthy lifestyles and manage chronic illnesses, or prevent other medical conditions • Follow-up care for identified BH needs, monitoring of outcomes and care processes for chronic care • Timely adjustment of care and coordination • Social / family support to include BH factors in chronic care or consultation with other staff • Ability to address patterns of ineffective healthcare utilization such as overuse, misuse, underuse, or ineffective use • Identify complex or high risk/high cost patients with BH conditions or contributing factors to chronic illnesses needing specialty care and refer to specialty providers when necessary
<p>Element 1: Team</p> <p><i>B. With shared operations, workflows and practice culture for integrating BH</i></p>	
<p>Scope One</p> <p>B. Specified shared workflows (processes & roles) for integrating care of MH/SA conditions in PC that assure:</p> <ul style="list-style-type: none"> • Regular communication, coordination, and collaboration between PCP, BHP, practice team, and patient / family throughout care process 	<p>Scope Two</p> <p>B. Specified shared workflows (processes & roles) for integrating care of BH contribution factors to common chronic illnesses that assure</p> <ul style="list-style-type: none"> • Regular communication, coordination, and collaboration between PCP, BHP, practice team, and patient / family

<ul style="list-style-type: none"> Reliable execution of the 5 systematic clinical approaches enabled by systems outlined in point #3 as relevant to integrated care of MH/SA conditions 	<p>throughout care process</p> <ul style="list-style-type: none"> Reliable execution of the 5 systematic clinical approaches enabled by systems outlined in point #3 as relevant to integrated care of BH contributing factors to chronic illness
<p>Element 1: Team <i>C. Having had formal or on-the-job training in preparation for the clinical roles and relationships of collaborative care, including but not limited to culture and team-building</i></p>	
<p>Scope One C. Evidence that PC and BH providers (and key staff) are prepared through training or experience to carry out the necessary clinical and operational functions to provide collaborative team-based care to patients with MH/SA needs</p>	<p>Scope Two C. Evidence that PC and BH providers (and key staff) are prepared through training or experience to carry out the necessary clinical and operational functions to provide collaborative team-based care to patients with BH contributing factors to common chronic illnesses</p>
<p>Element 2: Shared Population and Mission <i>A panel of patients in common (shared across medical and behavioral health providers) for total health outcomes (behavioral & physical)</i></p>	
<p>The practice has identified or has been attributed with a specific panel or population of patients that consider the practice their place for care or ‘medical home’—and for which the clinic feels responsible for total primary care. This is modified by scope to include different scope of integrated BH:</p>	
<p>Scope One Those patients in the clinic panel with MH and SA conditions (within the scope of primary care)</p>	<p>Scope Two: Scope One PLUS Chronic illnesses/medical conditions with BH contributing factors</p>

Element 3: Systematic Clinical Approach with systems that enable it to function

<p>A. <u>Patient identification</u>: Employing methods to identify those members of the population who need or may benefit from BH integration</p> <p>B. <u>Patient engagement</u>: Engaging patients and families in identifying their needs for care and particular clinicians to provide it;</p> <p>C. <u>Shared care plan</u>: Using an explicit, unified and shared care plan (one unified plan, rather than separate medical and behavioral health care plans)</p> <p>D. <u>Shared electronic record</u>: The unified care plan and manner of support to patient and family in a shared electronic health record</p> <p>E. <u>Systematic follow-up & adjustment</u> of treatment plans if patients are not improving as expected</p>	<p>Scope 1</p> <p>Elements (A-E in) are in place for:</p> <p>Integrated behavioral health care of patients with MH and SA conditions (within the scope of primary care)</p>	<p>Scope Two: Scope One</p> <p>PLUS</p> <p>Elements (A-E) are in place for integrated behavioral health care of patients with medical conditions with BH contributing factors and need for health behavior change</p>
<p>Practices can describe how each of these elements in the clinical approach works in that practice, with whatever scope of integrated behavioral health has been chosen</p>		

Federal Grant Name	Issuing Agency	Description
Behavioral Risk Factor Surveillance System (BRFSS)	CDC & HHS	National survey with state specific questions
HSV Social Security (Death)	Social Security Administration	Tracks deaths
HSV National Violent Death Reporting System	CDC & HHS	Tracks violent deaths
HSV Behavioral Risk Factor Surveillance System	CDC & HHS	Same as BRFSS?
Pregnancy Risk Assessment Monitoring System	CDC	
HSV Death Records Department of State	Dept. of State	
Electronic Verification of Vital Event Systems	Nat'l Assn for Public Health Stastics and Information Systems	
Preventive Block Grant Allocation	CDC	
Colorado ELC: Food Safety Modernization	CDC & HHS	
Surveillance of Autism Spectrum Disorders	CDC & HHS	
Behavioral Surveillance System	CDC & HHS	
Comprehensive STD Prevention Systems	CDC & HHS	
Refugee Preventative Health	HHS	
Emerging Infections Program	CDC & HHS	
HIV/AIDS Surveillance	CDC & HHS	
HIV Prevention Project	CDC & HHS	
Epidemiology and Laboratory Capacity for Infectious Diseases	CDC & HHS	
STD/HIV Prev Training Centers	CDC & HHS	
Adult Viral Hepatitis Prevention Coordinator	CDC & HHS	

ATSDR Capacity Site Specific Activities	CDC & HHS	
Nat'l Environmental Public Health Tracking	CDC & HHS	
STD Surveillance Network	CDC & HHS	
TB Elimination and Laboratory	CDC & HHS	
Muscular Dystrophy Surveillance Tracking	CDC & HHS	
Surveillance of Fetal Alcohol Syndrome	CDC & HHS	
Surveillance for Disease among Immigrants and Refugees	CDC & HHS	
Reducing Risks for Alcohol Exposed Pregnancy	CDC & HHS	Seeks to prevent fetal alcohol syndrome
Emerging Infections Program	CDC & HHS	
Ryan White Care Act Title II	HRSA	
EPI & Lab Capacity For Infectious Diseases	CDC & HHS	
EPI Birth Defect Surveillance	CDC & HHS	
Occupational Safety and Health Statistics	Dept of Labor	
Colorado Refugee Wellness Center	HHS	
CRSP Refugee Program	Colorado DHS	
Diagnosing Latent TB Infection	CDC & HHS	
Iowa Stillbirth Surveillance Project	Univ. of Iowa	CO extension of program
S. Carolina Rare Conditions Surveillance	Univ. of S. Carolina	CO extension of program

Existing Demonstrations and Waivers Granted to the State by CMS – Adult

NAME OF WAIVER	HCBS WAIVER for PERSONS with BRAIN INJURY (HCBS-BI)	COMMUNITY MENTAL HEALTH SUPPORTS WAIVER (HCBS-CMHS)	HCBS WAIVER for PERSONS LIVING WITH AIDS (HCBS-PLWA)	HCBS WAIVER for PERSONS who are ELDERLY, BLIND, AND DISABLED (HCBS-EBD)	HCBS WAIVER for PERSONS with SPINAL CORD INJURY (HCBS-SCI)	SUPPORTED LIVING SERVICES WAIVER (HCBS-SLS)	WAIVER for PERSONS with DEVELOPMENTAL DISABILITIES (HCBS-DD)
What is the primary purpose of this waiver?	To provide a home or community based alternative to hospital or specialized nursing facility care for persons with brain injury.	To provide a home or community based alternative to nursing facility care for persons with major mental illness.	To provide a home or community based alternative to hospital or nursing facility care for persons living with HIV/AIDS.	To provide a home or community based alternative to nursing facility care for elderly, blind, and disabled persons.	To provide a home or community based alternative to nursing care for persons with a spinal cord injury.	To provide persons with developmental disabilities supported living services in the person’s home or community.	To provide to persons with developmental disabilities services and supports which allow them to continue to live in the community.
Who is served?	Persons with brain injury as defined in the Colorado Code of Regulations with specific diagnostic codes.	Persons with a diagnosis of major mental illness as defined in the Colorado Code of Regulations with specific DSM-IV diagnostic codes.	Persons with a diagnosis of HIV/AIDS.	Elderly persons with a functional impairment (aged 65+) or blind or physically disabled persons (aged 18-64).	Persons with a spinal cord injury as defined in the Colorado Code of Regulation with specific diagnostic codes.	Persons, who can either live independently with limited supports or who, if they need extensive supports, are	Persons who are in need of services and supports 24 hours a day that will allow them to live safely and participate in the community.

						already receiving that high level of support from other sources, such as family.	
What is the active enrollment cap on the program	500 persons	2,954 persons	200 persons	22,384 persons	67 persons	3,012 persons	4,007 persons
Is there a waiting list?	Yes, for nursing facility level of care in the Supported Living Program	No	No	No	No	Yes	Yes
What is the Level of Care Requirement?	Hospital or nursing facility level of care.	Nursing facility level of care.	Nursing facility or hospital level of care.	Nursing facility level of care.	Nursing facility level of care.	Intermediate Care Facility for Individuals with Intellectual Disabilities.	Intermediate Care Facility for Individuals with Intellectual Disabilities.

What waiver services are available?	Adult day services Specialized Medical Equipment & Supplies Behavioral management Day treatment Home modifications Mental health counseling Non-medical transportation Personal care Respite care Substance Abuse Counseling Supported Living Program Transitional Living Personalized Emergency Response System	Adult day services Alternative care facilities Consumer Directed Attendant Supportive Services(CDASS) Personal Emergency Response System Home modifications Homemaker services Non-medical transportation Personal care Respite care	Adult day services Personal Emergency Response System Homemaker services Non-medical transportation Personal care	Adult day services Alternative care facilities Community transition services Consumer Directed Attendant Supportive Services(CDASS) Personal Emergency Response System Home modifications Homemaker services In home support services (IHSS) Non-medical transportation Personal care Respite care	Adult day services Alternative Therapies(Acupuncture, Chiropractic, Massage) Consumer Directed Attendant Supportive Services(CDASS) In-Home Support Service (IHSS) Personal Emergency Response System Home modifications Homemaker services Non-medical transportation Personal care Respite care	Assistive Technology Behavioral Services Day habilitation services (Specialized Habilitation, Supported Community Connections) Dental services Support Employment Prevocational Services Home Modification Homemaker Services Mentorship Personal Care Services Personalized Emergency Response System (PERS) Professional Services (Includes Hippotherapy, Massage &	Behavioral Services Day Habilitation (Specialized Habilitation, Supported Community Connections) Prevocational Services Dental Services Residential habilitation (24 hour individual or group) Transportation Specialized medical equipment and supplies Supported Employment Vision Services
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						Movement Therapy) Respite Services Specialized Medical Equipment & Supplies Transportatio n Vehicle Modification s Vision services	
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Original source:

<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251856249656&ssbinary=true>

Existing Demonstrations and Waivers Granted to the State by CMS – Child

NAME OF WAIVER	CHILDREN'S HCBS WAIVER (CHILDREN'S HCBS)	HCBS – CHILDREN WITH AUTISM WAIVER (HCBS-CWA)	CHILDREN'S EXTENSIVE SUPPORT WAIVER (HCBS-CES)	CHILDREN'S HABILITATION RESIDENTIAL PROGRAM WAIVER (HCBS-CHRP)	WAIVER for CHILDREN with a LIFE-LIMITING ILLNESS (HCBS-CLLI)
What is the primary purpose of this waiver?	To provide Medicaid benefits in the home or community for disabled children who would otherwise be ineligible for Medicaid due to excess parental income and/or resources. Children must be at risk of nursing facility or hospital placement. Children must meet additional targeting criteria.	To provide Medicaid benefits in the home or community for children with a medical diagnosis of Autism. Children must meet additional targeted criteria.	To provide Medicaid benefits in the home or community for children with developmental disabilities or delays that are most in need due to the severity of their disability. Children must meet additional targeted criteria.	To provide habilitative services for children and youth in foster care who have a developmental disability and extraordinary needs. Children must be at risk for institutionalization.	To provide Medicaid benefits in the home for children with a life limiting illness. To allow the family to seek curative treatment while the child is receiving palliative care.
What ages are served?	Birth through age 17	Birth through age 5	Birth through age 17	Birth through age 20	Birth through age 18
Who is served?	Disabled children in the home at risk of nursing facility or hospital placement.	Children medically diagnosed with Autism with intensive	Children with intensive behavioral or medical needs who	Children age 0-20 years of age, who are in the custody of the County	Children with a life limiting illness who can be safely cared for in the home and who

		behavioral needs who are at risk of institutionalization in an Intermittent Care Facility (ICF)	are at risk of institutionalization. Children, birth through age 4, must have a developmental delay. Children, 5 through 17, must have a developmental disability.	Department of Human/Social Services, residing in an out-of-home CHRP approved placement and have a developmental disability (developmental delay age 0-4).	are at risk of institutionalization in a hospital.
What is the active enrollment cap on the program	1,308 Children	75 Children	393 Children	160-200 Children	200 Children
Is there a waiting list?	Yes	Yes	Yes	No	No
What is the Level of Care Requirement?	Nursing facility or hospital level of care.	Intermediate Care Facility for Individuals with Intellectual Disabilities. Diagnosed with Autism. Under 6 years of age.	Intermediate Care Facility for Individuals with Intellectual Disabilities.	Intermediate Care Facility for Individuals with Intellectual Disabilities.	Hospital level of care with a life limiting illness where death is highly probable before adulthood.

SIM Contractor Final Report: Health Care Status for Both Ute Tribes

Colorado's two Federally recognized Tribes, the Ute Mountain Ute Tribe (UMUT) and the Southern Ute Indian Tribe (SUIT), provide quality health care to their members at their respective health clinics. Both Tribes would benefit from consistent and increased funding, which would allow for building expansion and hiring of additional medical personnel at both sites. The two Ute Tribes would like to have a greater focus on preventative care, integrated health care, and culturally relevant nutritional and educational programs.

1. What is the “as is” state of health in Colorado from this sector/stakeholder perspective?

Health Care Status for Both Ute Tribes

Health care for American Indians and Alaskan Natives is a fiduciary responsibility of the U.S. government, and Indian Health Service (IHS) was established within the U.S. Department of Health and Human Services to provide health care to members of Federally recognized Tribes. IHS provides two types of services, direct health care services, which are provided by an IHS and Tribal facilities, and contract health services (CHS), which are provided by a non-IHS/Tribal facilities. The eligibility requirements are stricter for CHS than for direct care. CHS is not an entitlement program, and an IHS referral does not imply the care will be paid. If IHS is requested to pay, then a patient must meet the residency requirements, notification requirements, medical priority, and use of alternate resources. Patients must notify IHS within 72 hours of the use of those outside (self-referral) emergency CHS services. Elders may have up to 30 days to notify IHS.

Health care is administered differently between the two Ute Tribes. The Ute Mountain Ute Tribe's health services are primarily administered by IHS at the Ute Mountain Ute Health Center (UMUHC). The Ute Mountain Ute Tribe also has some health services it manages under a 638 contract such as EMS/Ambulance services, Public Health Nursing, Community Health Representatives, Special Diabetes Program, Health Educator, and Mental Health Technician services. Tribes can take over their own health care services through a 638 contract (PL 93-638 Indian Self-Determination and Educational Assistance Act), which transfers the responsibility of

health care from the Federal government to the Tribe. The Southern Ute Indian Tribe has a 638 contract for health care.

Access for Both Ute Tribes

- Eligibility
 - Although there are different legal definitions of the word “Indian,” members of Federally recognized Tribes and their descendants may obtain care at any IHS hospital or clinic if the facility has the staff and capability to provide the medical care.
 - American Indians and Alaskan Natives are entitled to state health care services on the same basis as all other state citizens. Medicare, Medicaid and the State Children’s Health Insurance Program (CHIP) must be fully available to eligible Indian people.
- Veterans
 - Currently many military veterans cannot fully utilize health services of the Veteran’s Administrations health care system because of the long distances for travel to such cities as Grand Junction or Albuquerque in order to obtain services.
 - However, those veterans can access the IHS for care, and the VA reimburses IHS for direct care services provided to eligible American Indian and Alaskan Native Veterans. VA copayments do not apply to services provided by IHS.
- Health Services in Rural Areas
 - The Southern Colorado Ute Service Unit (SCUSU) provides ambulatory care services through two health centers located in Towaoc (Ute Mountain Ute Health Center/UMUHC) and Ignacio (Southern Ute Health Center/SUHC), Colorado, and a field health station in White Mesa, Utah, which is a satellite of the UMUHC.
 - Although many urban and rural areas have IHS Clinics, if a patient requires more serious medical treatment at a hospital, American Indians and Alaskan Natives from Colorado must travel to the nearest IHS hospital. For Coloradoans, the closest full-fledged IHS hospital is the Northern Navajo Medical Center (NNMC) in Shiprock, New Mexico. Unfortunately, traveling is not conducive to emergency

situations or for people who are too ill or cannot afford to travel such long distances. Therefore, IHS beneficiaries in SW Colorado and SE Utah may have to go to hospitals in Cortez, Colorado, Durango, Colorado, Blanding, Utah, or even farther.

- IHS has some telemedicine capacity, such as performing retinal readings and providing some psychiatry services. IHS may be starting telemedicine services for dermatology.
- Health Services in Urban Areas
 - Denver Indian Health and Family Services offers a health clinic for American Indians and Alaskan Natives. However, many American Indians and Alaskan Natives residing in the Colorado Springs area do not have access to a similar clinic and must travel to receive services.
 - Eligibility for services can be an issue for Tribal members, particularly those in transition from Tribal lands to urban areas. Currently, there are not stabilization centers for individuals needing services in urban areas. There is a disconnect with determination of eligibility for Medicaid, TANF, and other support services.

Quality for Both Ute Tribes

- Mental health services for urban Indians appear to be lacking. According to the Community Health Profile for Denver Indian Health and Family Services prepared by the Urban Indian Health Institute (UIHI) in 2011, urban Indians report rarely or never receiving the emotional and social support that they need (13.5%) compared to the general population (6.0%).

Costs for Both Ute Tribes

- The saying “don’t get sick after June,” is common in Indian Country and references the reality that many CHS programs run out of funding around the last quarter of the fiscal year, usually in June/July. When the funding is gone, many Native Americans simply do not have access to adequate and affordable health care through their CHS Programs. Tribal Health Departments can apply for other federal funds through the Catastrophic Health Emergency Fund (CHEF), which help cover major emergency cases with costs

exceeding \$25,000, but there is no guarantee these funds will actually be available. Please remember that CHEF funds come from CHS, and when CHS funds are gone so are CHEF funds.

- Some Tribal members experience difficulty when filing their taxes in regard to health care. The U.S. Department of Health and Human Services (HHS) extended the hardship credit to IHS, but an advanced tax credit could pose a problem for seasonal workers because they may owe the IRS money at the end of the year.
- There is sometimes a problem of “premium aggregation.”
- Navigating different payers (federal, state, county, Exchange, Medicaid and Medicare, and private insurance) can be difficult.
- According to the Community Health Profile for Denver Indian Health and Family Services prepared by the Urban Indian Health Institute (UIHI) in 2011, 23.1% of American Indians reported being unable to see a doctor due to cost than the general population (12.3%).
- Currently when IHS issues a patient an external referral, IHS will pay only for CHS Priority 1 referrals, which are to prevent immediate death or serious impairments. IHS does not pay for CHS Priority 2 and lower referrals.

Health Care Status for the Ute Mountain Ute Tribe

Indian Health Service as previously mentioned has an ambulatory health center in Towaoc, Colorado, on the Ute Mountain Ute Reservation called the Ute Mountain Ute Health Center (UMUHC). The UMUHC has a satellite facility in White Mesa, Utah, also on the Ute Mountain Ute Reservation called the White Mesa Health Station. The nearest IHS Hospital for Ute Mountain Ute Tribal members living on the reservation is the Northern Navajo Medical Center in Shiprock, New Mexico. The UMUHC in FY 13 had 13,507 living patients registered at the facility, had over 28,000 patient visits, and issued 40,594 prescriptions.

The UMUHC provides many essential services to Ute Mountain Ute Tribal members as well as patients from other Federally recognized Tribes and their descendants. The UMUHC offers care from family physicians, dentists, and optometrists, as well as visiting specialists.

Access for the Ute Mountain Ute Tribe

- UMUT does not currently utilize telemedicine services because they have local psychiatrists, and the retinal readings require technology/equipment that the UMUT does not currently have.
- The BIA juvenile detention center in Towaoc has exam rooms and a treatment facility that have never been opened because the project needs more support. IHS is cutting back on mental health and substance abuse funding and services, so this population in particular needs resources.
- The UMUHC is a one-stop shop for many healthcare needs. During a visit, many Tribal members who travel a great distance to the Health Center typically see multiple providers, including dentists, optometrists, and family physicians, which is a convenient option for patients.
- The UMUHC has three full time medical doctors, two of which are board certified in family practice, and one is board certified in internal medicine and pediatrics.
- The UMUHC hosts many visiting specialists; an adult and adolescent psychiatrist visits once every other month, and a child psychiatrist is available every other month also, such that the UMUHC has a psychiatrist once a month. An optometrist is available to see patients two days a week. A podiatrist visits once a week. A rheumatologist comes every three months. A nephrologist comes every month also. The UMUHC also works with outside contractors, who provide a registered dietician at the UMUHC two days a week and additional dentists to help supplement the work of the Chief Dental Officer.
- The UMUHC also has its own pharmacy, where most prescriptions are electronically transmitted via the electronic health record utilized by the UMUHC.
- The wait times at the UMUHC are quite short and even attract patients from surrounding areas, like from Shiprock, New Mexico, who want to avoid long wait times. Many people also go to the Ute Mountain Ute Health Center for dental and optometry appointments because getting an appointment for those services at other IHS facilities is sometimes difficult.
- A full time in-house clinical psychologist started in the beginning of October 2013. The clinical psychologist provides services for patients who self-refer, referrals from doctors in the facility, referrals from outside the facility, requests from the nearby BIA detention facility, various court and federal probation requests, etc. The psychologist may also visit

schools in local communities to work with students in the mornings before traveling to the Health Center for regular appointments.

Quality for the Ute Mountain Ute Tribe

- The Ute Mountain Ute Health Center is a high quality health system; patient satisfaction surveys indicate that 70 to 80 percent of patients are satisfied with their health care experiences.
- Patient paper health records have been converted to electronic health records, but paper charts are still used to store documents from other healthcare facilities, documents with patient signatures, and various third party payer documents. The dental department is the only department of the Health Center that does not utilize electronic health records, but as soon a new Chief Dental Officer is hired, the dental department will make the transition to electronic health records.
- If a Tribal member or descendant who is not from the Ute Mountain Ute Tribe visits the Health Center, then that patient must fill out all new forms because IHS does not have multi-facility health integration. IHS beneficiaries do not have unique chart numbers, so the same number at two different health facilities corresponds with two different patients. It would be convenient to have a multi-facility record system so that IHS beneficiaries Tribal members can receive services at any IHS location without filling out new paperwork.

Cost for the Ute Mountain Ute Tribe

- The Health Center pharmacy can transfer prescriptions to another pharmacy, but patients may end up having to pay for their prescriptions; although if the prescription is filled at the Health Center pharmacy, there is no cost to the patient.
- Patients may be referred out of the Health Center for specialized services. If patients are referred to another IHS facility, the referral is handled by IHS nurses internally; many patients from the Ute Mountain Ute Tribe are referred to the IHS facility in Shiprock,

New Mexico. If a patient is referred outside of the IHS system, however, the payment falls under CHS. CHS will only pay for Priority 1 referrals, which are made when there is a threat to life or limb. Priority 2 and 3 referral costs are incurred by the patient. If the patient has Medicaid, then Medicaid will pay for the referral. If the patient has another source of insurance, the patient will usually pay a deductible or co-pay for the referral services.

- The Ute Mountain Ute Tribe provides a self-funded health plan for its employees. Tribal Self-Funded Health Care Plans are not alternate resources for IHS CHS programs as are Medicaid etc.

Health Care Status for the Southern Ute Indian Tribe

The Federal government is typically responsible for health care services for American Indians and Alaskan Natives, but in 2009 the Southern Ute Indian Tribe (SUIT) assumed control of its own health services through a 638 contract. Through this contract, SUIT used federal funds from IHS along with third-party insurance and additional Tribal funding to localize health services. SUIT now operates its own Health Center.

The Southern Ute Indian Tribe's Health Department operates the Southern Ute Health Center, which is composed of the following areas: health services that help patients understand their conditions and treatments; clinical services including optometry, family services, and pharmaceutical services; dental services for most basic dental needs; nursing services including ambulatory care visits; behavioral health services for children and adults to help evaluate, diagnose, and manage mental, behavioral, chemical dependency, and emotional conditions; referral services that use tribal and federal funds when medically necessary services are not available from the department; a business office that bills and collects revenue and keeps patient records; and patient information and prevention services that provide information about chronic diseases. According to the Southern Ute Tribal Health Department's annual report for fiscal year 2012, the Health Center in 2011 served 9,269 living patients, 23,335 ambulatory care visits, and 33,648 prescriptions.

SUIT launched its own Tribal Member Health Benefit Program, which is a self-funded Tribal member health benefits program that focuses on obesity and access to care. SUIT's Health Benefit Plan has been accredited and was fully implemented October 1, 2013. The Program is designed to give incentives to Tribal members to use local services. The program covers Tribal members only, and members both in state and out-of-state will be given a Tribal Health Benefit Identification Card to improve access to needed services with doctors and hospitals around the country. One of the main goals of the Health Benefit Program is to efficiently manage the cost of providing services to SUIT members; the Program covers most services that members obtain outside of the Southern Ute Health Center without the need for an up-front payment like most doctors, hospitals, and clinics require today.

Within the next 60 days, there will be a modular building added, thereby doubling the capacity of the SUIT health clinic. However, additional personnel and space are still needed in order to expand services.

Access for the Southern Ute Indian Tribe

- Because some state and federal programs have criteria that are income based, SUIT members are often not eligible for Medicare, Medicaid, and CHIP.

Quality for the Southern Ute Indian Tribe

- The Southern Ute Health Center has expanded, and the volume and needs of patients have outgrown the current facility. To adequately serve its patients, the Health Center needs more space and medical personnel.

Cost for the Southern Ute Indian Tribe

- The SUIT Health Department has two programs to help eligible patients pay for services that cannot be provided at the Southern Ute Health Center in Ignacio: Contract Health Services and the Tribal Health Resource Pool. When no funds are available from CHS, Tribal members can access the Tribal health Resource Pool to cover additional charges

for services. The Pool was established in 2003 to help bridge the funding gap between the time when CHS runs out of money and when the new fiscal year begins. Although designed to supplement funding shortfalls, the Pool has grown substantially, and in 2011, more than \$6,000,000 were spent.

- In regard to referral services, all services to be considered for payment from CHS funds must be referred and approved before payment will be made. If a tribal member accesses additional or non-emergency services outside of the Southern Ute Health Center, those services do not qualify for payment from Contract Health Services funds and become the sole financial responsibility of the patient. If requests are made to cover services under the pool, then they must first be reviewed under the rules for Contract Health Services funding.
- Tribal members who do not reside in the vicinity of the Health Center have the option of using a tribal health center in their area, one operated either by the U.S. Indian Health Service or by a Tribe. In cases where there is no a tribal health service, the tribal member must either have private insurance pay for the services or ask for reimbursement from the pool.

2. What is the preferred “to be” state from that perspective?

Ideal Health Care for Both Ute Tribes

Both Ute Tribes would greatly benefit from consistent IHS funding throughout the fiscal year so that individuals seeking health services do not have to be turned away. In terms of quality of health care, two Ute Tribes would like to see:

- An increased focus on preventative care, which may require educational programs.
- Improvement of current healthcare facilities and development of new facilities, such as diabetes centers and wellness centers that focus on obesity and cardiovascular issues.
- An increased focus on the health and well-being of the elderly, including the development of nursing homes and programs that help connect the elderly with youth so that wisdom and culture can be shared.
- Integration of cultural traditions into nutrition initiatives.
- Improved food distribution to increase access to healthy foods.

- Coordinated physical and behavioral healthcare, such that an interdisciplinary team of people are working together for the patient.
- Enhanced behavioral health services at all levels, including emergency and short and long term care, as well as services that address a range of issues from substance abuse to psychiatric care.

Ideal Health Care for the Ute Mountain Ute Tribe

In terms of access, the Ute Mountain Ute Health Center would benefit from having an increased budget, which would allow the necessary improvements including extended hours, expansion of services, coordination of health programs, and funding for Priority 2 and lower levels of CHS referrals.

If the UMUHC were to be open into the evenings (until about 8 p.m.) and on Saturday mornings, more patients, particularly those with daytime responsibilities, would be able to access health care. The Utah Navajo Health Care System headquartered out of Montezuma Creek, Utah, is open well into the evening and has found that many Tribal members utilize that time to take care of their health issues.

Some services need more access for their patients. Optometry and nutrition patients would benefit from an expansion from 2 days a week to 5 and 1/2 days a week, medical (doctors, nurses, lab, and radiology) and dental patients would benefit by having evening and Saturday morning hours.

For the UMUHC, integrating the existing health and wellness programs (including clinic (UMUHC) services, EMS, and other Tribally operated health services) by having all programs under one roof and managed jointly or by one entity would streamline health care for Tribal members and help coordinate IHS and Tribal health care programs. Integrating behavioral and physical health may be beneficial to patients, especially in regard to reducing the stigma associated with mental health services. In an Tribally operated (638) health facility in Anchorage, Alaska, the exam rooms have a back door that is used when a health provider feels the need to call in a mental health professional. The mental health providers can enter from the back to work with a patient, thus avoiding the possible negative stigma. When the mental health provider is introduced in this way, patients are more likely to be receptive to care because patients do not have to arrange additional appointments. Additionally, due to budget constraints,

the Ute Mountain Ute Tribe has not hired a health director for its Tribal 638 health programs, who could help coordinate health and wellness programs to benefit all patients. The addition of another Tribal public health nurse would also help deliver quality services to patients.

The inability of CHS to pay for Priority 2 and lower referrals is frustrating for both patients and providers. If these lower level referrals could be paid for, then many minor health issues could be addressed, thereby avoiding even greater problems in the future. For example, a patient with a damaged rotator cuff in the shoulder who may not experience much pain may have a Priority 2 or lower referral, but the patient may not have adequate finances for the referral service and may opt to ignore the problem. Then, 10 or 20 years later, the patient's shoulder becomes arthritic and causes even more problems than before. If Priority 2 and lower referrals were paid for initially, health problems could be addressed immediately, avoiding more severe health problems and greater costs down the road.

Ideal Health Care for the Southern Ute Indian Tribe

For SUIT, finding a way to revert the Pool to a subsidiary role is key to sustaining funding. Additionally, an expanded clinic would increase the capacity for the Health Center to serve more patients.

3. What is the “innovation opportunity” (i.e., the gap between “as is” and “to be”) for this sector/stakeholder?

Members of both the Ute Mountain Ute Tribe and the Southern Ute Indian Tribe need to be enrolled in health care insurance that meets their individual needs.

Consistent funding for IHS is imperative to ensure continuous quality health care. The UMUHC needs to have more significant source of funding beyond IHS appropriations. The UMUHC collected a little over 1.7 million dollars in third party collections in FY 13. However, this is not enough to cover CHS needs let alone the expansion of services discussed in this document. The good news is that many more patients will be eligible for Medicaid under the Affordable Care Act, and the Health Center will need to work hard to get its patients' enrolled in Medicaid and other alternate resource programs. Enrolling patients into third party insurance would provide more sustainable funding for the Health Center.

The health facilities for both of the Tribes need to be updated and expanded. The UMUHC needs to be bigger in order to accommodate health care expansion. Not many modifications can be made to the existing structure due to limited surrounding space and support structures within the physical plant that cannot reasonably be remodeled. According to a medical architect who recently visited the Health Center, building a new facility would be less expensive than remodeling the existing structure. Likewise, the Southern Ute Indian Health Center would be able to accommodate more patients and deliver more services with more space and staff.

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

Performance Measures for Both Ute Tribes

- An increase in the number of patient visits would indicate that the health care system is improving by attracting more patients. Visits from more patients overall would signal that the Health Center has a good reputation for providing quality health care. More frequent visits from the same patient may be indicative of higher satisfaction and better management of health. The more patients, the more likely it is for the Health Centers to collect more third party payments.
- Monitoring the wait time for appointments would show whether the health care system operates efficiently and that the clinic is adequately staffed.

Performance measures for the Ute Mountain Ute Tribe

- The Government Performance and Results Act (GPRA) requires Indian Health Services demonstrate on an annual basis that funds are being used effectively. Each year IHS includes its GPRA report card to Congress as part of the IHS budget. GPRA measures include 21 administrative and clinical items to assess quality of care, such as access to facilities, cancer screenings, and immunization and blood pressure control. GPRA also measures how well IHS is doing in preventing diseases. According to the most recent GPRA report card, the UMUHC met 19 of the 21 indicators for GPRA Year 2013.
- For the UMUHC, having baseline data would be beneficial in evaluating the improvement of health care. The GPRA standards are reasonable goals. Progress can also be measured using patient satisfaction surveys; 80 percent satisfaction would indicate

success, but falling below 70 percent satisfaction would cause reason for concern.

Benchmarking staff satisfaction would also be a good indicator.

- The Ute Mountain Ute Health Center would also look to the number of referrals that can be paid for. Increased revenue collection from third parties would be reflective of having more people enrolled with third party insurance.

5. If the model Colorado plans to test is paying for integrated physical/behavioral health, what role can (sector/stakeholder group) play in facilitating that integration or measuring its impact? This is answer is not available.

SIM Contractor Final Report: Community Health Partnership (RCCO 7)

Reporting Period: July 1- September 30, 2013

Date Submitted: October 5, 2013

Contractor Name: Community Health Partnership (RCCO 7)

Grant Amount: \$30,000

Contractor Role: Regional Care Collaborative Organization (RCCO)

Section I. Abstract (Overview of accomplishments, outcomes, substantive findings, which you will describe in greater detail through the questions below)

Community Health Partnership (CHP) accomplished the scope of work outlined in the SIM grant report. CHP executed a data sharing agreement with Colorado Health Partnerships and AspenPointe Health Services in July 2013 in order to collaborate on care coordination activities for RCCO members in El Paso, Teller and Park Counties. Through the SIM grant process, all parties also were able to complete the discussion about the process for data sharing and create an implementation timetable. It is anticipated that data sharing at the population management level will begin in November while care coordination information sharing for individual patients began in late September.

CHP also began discussion about data sharing with Northeast Behavioral Health Partnership under the SIM grant. A data sharing agreement is in legal review at CHP and is expected to be executed in October. Northeast Behavioral Health Partnership serves Elbert County, where approximately 600 RCCO 7 members, or 1% of membership, reside. CHP is working to schedule a meeting with Centennial Mental Health Center, the community mental health center (CMHC) for Elbert County. Due to scheduling conflicts, that meeting is slated for early November.

Administrative services for Colorado Health Partnerships and for Northeast Behavioral Health Partnership are performed by Value Options. Value Options staff was present at meetings where data sharing processes were discussed. As a result, data sharing processes will be consistent across both BHOs, which will ease the administrative and technical support burden for all parties.

CHP was pleased that BHOs and CHMCs were willing to discuss and agree to data sharing for patients in common and that collaboration for care coordination can be accomplished. However, only after implementation of data sharing processes will CHP be able to report on the extent of actual collaboration for whole person care.

Section II. General Information

1. What is the “as is” state of health in Colorado from this sector/stakeholder perspective?

Integrated care in Medicaid and the RCCO system is nascent with physical health and mental health system coordination limited by interpretation of Health Insurance Portability and Accountability Act (HIPAA) rules regarding patient privacy. Further complicating matters are state laws that govern mental health and substance abuse information sharing. Another barrier to integrated care is the training mental and behavioral health professionals receive, which continually reinforces that all patient information is private and any sharing, even for the benefit of the client, could result in negative consequences for the practitioners' licensure.

RCCO 7 has a close relationship with AspenPointe Health Services, the CMHC for 99% of RCCO 7 members. The September roster report for RCCO 7 shows that 66.5% of members are attributed to a primary care medical provider (PCMP) that has either an embedded or co-located

behavioral health counselor from AspenPointe or other resource. In addition, AspenPointe has an embedded provider from Peak Vista Community Health Centers, a RCCO 7 PCMP.

2. What is the preferred “to be” state from that perspective?

RCCO 7 would prefer that BHOs, CHMCs and physical health providers share minimum data necessary for care coordination purposes with a goal of treating people wholly, promoting person-centered care, and creating one, integrated treatment plan. The barriers to this vision are created by separate payment systems for physical and behavioral health care, lack of contractual direction from the state for BHOs and RCCOs to share information and collaborate, unaligned goals and deliverables for BHO and RCCO contracts, and individual agency interpretation of HIPAA and state rules governing substance abuse disorder disclosures.

3. What is the “innovation opportunity” (i.e., the gap between “as is” and “to be”) for this sector/stakeholder?

The innovation opportunity exists at the state level for system-wide change. Colorado’s state agencies that contract with local agencies to provide behavioral and/or physical health services could foster collaboration by aligning payment systems and contract deliverables among BHO and RCCO contracts. State agencies also could require collaboration among RCCOs and BHOs in contracts. State agencies could be partners in information sharing, as the state is owner and holder of all claims and encounter data from the BHOs as well as physical health claims. Lastly, the state as Medicaid payer has the opportunity to articulate and incentivize desired health outcomes for the populations served.

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

The state needs to define integrated care before a framework for integrated care can exist. Once the definition and framework are defined, process and outcomes measures can be identified and assessed. Progress toward creating a system of integrated care could be measured by: the number of integrated primary care providers (including co-located providers); number of integrated

primary care providers utilizing physical health and behavioral health assessment tools; cost of care by primary and secondary diagnosis; number of referrals out for services that should be conducted in integrated primary care settings; access to care for integrated primary care settings; clinical outcomes relative to integrated care; provider satisfaction; and patient satisfaction scores.

5. If the model Colorado plans to test is paying for integrated physical/behavioral health, what role can (sector/stakeholder group) play in facilitating that integration or measuring its impact?

When HCPF moves toward an at-risk model for the RCCO system, RCCOs can facilitate physical and behavioral health integration by taking a systematic approach to partnerships that foster integrated care and care coordination for Medicaid members. By managing one payment for integrated care, RCCOs can eliminate system inefficiency and inflation often caused by the fee-for service environment or caused by competing systems of care. RCCOs are well positioned to facilitate integrated care because they have been building relationships with PCMPs and supporting PCMPs via practice transformation activities to move PCMPs toward integrated care and medical home models.

Section III. SIM Grant Deliverables

Deliverable 1: By September 30, 2013, execute data sharing agreements and Business Associate Agreements (BAA) with Behavioral Health Organizations (BHO) and community mental health centers (CMHC) serving Park, Teller, El Paso and Elbert Counties.

Status: Substantially completed. Agreements executed with BHO and CMHC covering El Paso, Teller, and Park Counties. Approximately, 99% of RCCO 7 members live in El Paso, Teller and Park Counties. Data sharing agreement with BHO and CMHC for Elbert County is in legal review. All parties are eager to execute and anticipate completion in October 2013.

Community Health Partnership (CHP) executed a data sharing agreement effective July 1, 2013 with Colorado Health Partnerships and AspenPointe Health Services. The agreement states that

the Parties will work together to determine protocols for sharing data at the population level for health management purposes and at the individual patient level for care coordination purposes. Protocols will be complete by September 30, 2013 (see Deliverable #3). In addition, AspenPointe began using a standard release of information form with all patients on August 1, 2013, which included releasing information to the RCCO for the purposes of care coordination. AspenPointe and Colorado Health Partnerships serve Park, Teller, and El Paso Counties.

Outreach began on July 25, 2013 to Northeast Behavioral Health Partnership and Centennial Mental Health Center, the BHO and CMHC for Elbert County, respectively. CHP met with Northeast Behavioral Health Partnerships staff on September 11, 2013 and discussed ways to work together. A draft data sharing agreement was presented during the meeting and is currently in legal review. At the same meeting, data sharing processes were discussed. It was agreed that the same data sharing methodology utilized for CHP and Colorado Health Partnerships data sharing would be used for the exchange between Northeast Behavioral Health Partnership and CHP. This reduces the work burden for all parties, especially as Value Options is the service provider that will provide data for both BHOs.

Explanation of Variance (If applicable): The data sharing agreement between CHP and Northeast Behavioral Health Partnership will be signed in October. This covers approximately 1% of RCCO 7's population. Legal review has slightly delayed execution; however, the intent of all parties is to execute the agreement and share data for care coordination purposes as quickly as possible.

Deliverable 2: By August 31, 2013, review and summarize the accuracy, timeliness and usefulness of the BHO encounter data as provided by TREO, the state data analytics contractor (SDAC).

Status: Complete.

CHP, AspenPointe Health Network, AspenPointe (CMHC), and Value Options staff met to review SDAC data fields for care coordination purposes. Because SDAC claims data is time lagged, it is most useful for population health management rather than emergent care coordination needs. SDAC BHO data is incomplete as well. For example, SDAC data contains prescription information but not prescriber information if the prescription originated from a BHO provider.

As a part of the data sharing agreement between the RCCO and BHO, data fields (name/ID, primary diagnosis, date of service, service provider, and pharmacy) will be shared bi-directionally to help with population health interventions and member identification for care coordination.

RCCO and BHO staff also met with the Colorado Health Institute (CHI) to discuss ways HCPF and the SDAC can better support the provision of BHO encounter data in the SDAC. CHI will report a summary of the discussion in its final report to HCPF. The RCCO will summarize its assessment of BHO data available via the SDAC in its final report.

Explanation of Variance (If applicable): N/A

Deliverable 3: By September 30, 2013, develop patient identification, data sharing and communication protocols for the transfer of population level data and patient level data between each BHO/CMHC and the RCCO.

Status: Complete.

RCCO, BHO and CMHC representatives met in August and September to finalize the process and plan for sharing data necessary for care coordination.

I. Population Data for population health management

BHO shall provide Population Data to the RCCO Population Data to include, but may not be limited to, the following administrative, claims data for individuals enrolled in Medicaid and served by BHO:

- Patient name and identifier
- Illness burden category (if available)
- Primary and secondary diagnoses
- CPT or UB Services codes
- Date of service
- Payment amount
- Provider of service, to include provider location code and service address
- Raw claims
- Appointment and missed appointment information (if available)
- Work product analysis and high level reports of shared population

Population Data shall be shared monthly with the RCCO via secure exchange.

II. Patient Data for individual care coordination

CMHC shall provide the RCCO with the information listed below for specific patients as requested by RCCO and as authorized by the patient's signed Release of Information. Patient Data shall include information sufficient for RCCO to conduct care coordination and to develop care management programs in partnership with the BHO. Psychotherapy notes are not requested and will not be included in data shared. In particular, Patient Data shall include:

- Patient name and identifier
- Provider of service
- Primary and secondary diagnoses
- Treatment Plans
- Medical and community resource referrals
- Prescriptions written

- BHO case manager contact information
- Care plan

RCCO shall provide CMHCs with Clinical Records for specific patients as requested by CMHC. Patient Data shall include information sufficient for CMHC to conduct care coordination and to develop care management programs in partnership with the RCCO. In particular, Patient Data shall include:

- Patient name and identifier
- Provider of service
- Primary and secondary diagnoses
- Treatment plans
- Medical and community resource referrals
- Prescriptions written
- RCCO and/or PCMP care manager contact information (if applicable)
- Care plan

The process for sharing data for individual care coordination shall be at monthly meetings.

SIM Contractor Final Report: Perry Dickinson, MD, University of Colorado, Department of Family Medicine

Reporting Period: July 1 – November 15, 2013

Date Submitted: 11/26/13

Contractor Name: Perry Dickinson, MD, University of Colorado, Department of Family Medicine

Grant Amount: \$50,000

Contractor Role: Develop Practice Transformation Roadmap for Colorado SIM Project

Abstract

Colorado has a very solid base of primary care practices, but there is a substantial gap between the current status and what will be necessary to accomplish the aims of the SIM project and to improve value in the health care system. Most primary care practices recognize the need for implementation of an enhanced model of comprehensive primary care that includes integrated behavioral health services. However, practices also identify that payment reform and practice transformation support will be necessary to accomplish these substantial changes in care. While many Colorado primary care practices have been able to take advantage of practice transformation support services provided by HealthTeamWorks, Rocky Mountain Health Plans, the Colorado Rural Health Center, and others, most Colorado practices still need substantial support for implementing basic comprehensive primary care practice enhancements. Additional support will be necessary for practices to then progress to behavioral health integration. A statewide framework built on an extension service model will be necessary for a coordinated, coherent, and timely effort to transform Colorado primary care practices. Such a framework would have local extension agents interacting with practices to assess practice readiness, develop tailored practice transformation plans, and coordinate the provision of practice support services. The extension agents could also assist with convening primary care practices, behavioral health providers, other health care providers, public health agencies, and community organizations for efforts to improve health care, work on the community health plan, and accomplish the Triple Aim.

Deliverables

Deliverable 1: The University of Colorado Denver School of Medicine’s Dr. Perry Dickinson and his team (Practice Transformation Team) shall develop a practice transformation roadmap for the state of Colorado to achieve the integration of behavioral health within primary care settings.

Current Status: A draft of the practice transformation roadmap was developed and circulated to the developers of several other key portions of the SIM project report. A revised draft was provided to HCPF on October 15 for comments and suggested revisions. Based on these comments and those of other reviewers, a final draft was provided to HCPF on November 4 and will be appended to this report.

Explanation of Variance (If applicable): No variance.

Deliverable 2: The Practice Transformation Team shall travel to Grand Junction as needed to work with Rocky Mountain Health Maintenance Organization (RMHMO) to develop the practice transformation roadmap and leverage RMHMO’s efforts to assist primary care providers with work flow changes, use of data to manage and coordinate care, and the treatment with specific types of patients with chronic behavioral and physical health conditions. This roadmap will:

- i. Detail how RMHMO’s model can be applied statewide and will identify other resources and supports that are necessary to ensure practice transformation.
- ii. Identify other resources and supports that are necessary to ensure practice transformation.
- iii. Identify interventions that are comprehensive and include both clinical and operational tools and supports, practice coaching, client materials, web-based resources and directories, as well as practice-specific data and reports.

Current Status: Dr. Dickinson had a series of discussions regarding the roadmap with Patrick Gordon from RMHP, and the draft roadmap provided to HCPF was also provided to RMHP for comment and suggestions.

Explanation of Variance (If applicable): No variance

Deliverable 3: The Practice Transformation Team shall consult with Regional Care Collaborative Organizations (RCCOs) and other primary care providers on: 1) what type(s)/degree of practice transformation resources and supports are needed, and 2) to what degree primary care providers and RCCOs have already developed and implemented supports that may be leveraged in this effort.

Current Status: Interviews were done with representatives from each of the RCCOs, and a report of the results was provided to HCPF along with the roadmap.

Explanation of Variance (If applicable): No variance

Deliverable 4: The Practice Transformation Team shall provide a Final Report that includes, at a minimum, all of the following:

- i. A summary of activities attempted and completed by the Contractor regarding the SIM Cooperative Agreement.
- ii. A comprehensive roadmap for promoting practice transformation efforts statewide that includes resources and supports needed to ensure practice transformation is accomplished statewide and builds off of RMHMO's model.
- iii. Identification of any other activities necessary for the success of practice transformation efforts, including how the following key practice transformation components will be supports statewide.
 1. Utilizing data in the practice setting for population health management.
 2. Integrating behavioral health and primary care services.

Current Status: This report was provided to HCPF on November 4 and will be attached.

Explanation of Variance (If applicable): No variance

Overview

- Accomplishments

This project resulted in the development of a roadmap for practice transformation, both in general but also specifically for the Colorado SIM project. The development of the roadmap was integrated with the planning of other aspects of the SIM planning process and should integrate well with the rest of the SIM plans.

- Outcomes

The primary outcome is the practice transformation roadmap, although the accomplishment of a general understanding and consensus regarding the need for a statewide framework for practice transformation is also a major outcome. Multiple groups involved in the SIM planning should have a much improved understanding of practice transformation at this point.

- substantive findings

The level of support for the formation of a statewide framework such as a health extension service was surprising. The primary concern regarding such a framework appears to be a desire to make sure that local tailoring in the design and provision of services be allowed in order to respond to local conditions. However, this is completely consistent with an extension service model and definitely needs to be factored into the design of practice transformation support services.

- self-evaluation

Considering the tight timeline and the somewhat chaotic and shifting nature of the SIM project, I believe that we were able to integrate our practice transformation planning process well with the other aspects of the project and deliver a very solid roadmap for practice transformation for Colorado.

- Problems encountered

The primary problem encountered was the need to respond to an ever-shifting SIM framework, including incomplete plans for payment system reforms and required measures. However, this was completely unavoidable considering the tight timeline and ongoing planning process for everyone involved in the project. The other major problem was the remarkable lack of coherent data regarding primary care practices and providers in the state, with multiple data sources presenting sometimes widely divergent

information. We are continuing to work on developing an accurate database regarding the location, key characteristics, and level of progress toward transformation of Colorado primary care practices so that this won't be a major problem in the future.

Suggestions/Recommendations

Recommendations for the provision of practice transformation support services are detailed in the appended final Practice Transformation Roadmap.

Additional Information

None

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SIM Practice Transformation Final Report

B. A summary of activities attempted and completed by the Contractor regarding the SIM Cooperative Agreement.

- i. Interviews were performed with representatives from each of the RCCO districts to understand the practice transformation and practice support currently provided through the RCCOs and the perceived need for additional practice transformation support for the RCCOs and the practices. A report of the results of these interviews is attached to this report as Appendix A.
- ii. The project leader also had several discussions of the developing plans for practice transformation with other RCCO key informants, including one extensive meeting with Genie Pritchett, M.D., the Senior Vice President of Medical Services for Colorado Access, and three meetings with Patrick Gordon, the Associate Vice President and Director of Governmental Programs for Rocky Mountain Health Plans. In addition, a copy of the draft Practice Transformation Roadmap was provided to Patrick Gordon for comments and suggestions.
- iii. Numerous meetings were held with various groups involved with developing other portions of the SIM report, including discussions with the Colorado Health Institute, CORHIO, and CIVHC and ongoing meetings with Ben Miller's team that was developing the overall SIM framework. This included ongoing meetings and email exchanges with groups and consultants involved with the design of the payment methodology and the evaluation plans. In addition text was provided at the request of the other groups for inclusion in the Workforce, Payment Methods, Delivery System Design, and Public Health chapters of the SIM report.
- iv. As the Practice Transformation Roadmap was being developed, it became clear that data regarding the primary care workforce and practices in Colorado was very inadequate for developing these plans. Our team consulted with multiple groups, including the Colorado Health Institute, CIVHC, Health TeamWorks, the

Colorado Association of Family Medicine Residencies, the Colorado AHEC, the Colorado Department of Public Health and Environment, and the Colorado Department of Health Care Policy and Financing. Data regarding practice numbers, locations, PCMH recognition, Meaningful Use status, and other key practice information has not been collected or maintained in a systematic manner. Disturbingly, data from different major sources have not been consistent with each other. Our team has begun the process of pulling together multiple data sources in order to maintain a database on primary care practices and community resources, and we used our best estimates based on the available data in the Practice Transformation Roadmap.

- v. Drafts of the practice transformation plans and roadmap have been provided to multiple groups for feedback, including key informants from HCPF, Health TeamWorks, Rocky Mountain Health Plans, and CIVHC, and their feedback has been incorporated into this final version.
- C. A comprehensive roadmap for promoting practice transformation efforts statewide that includes resources and supports needed to ensure practice transformation is accomplished statewide and builds off of RMHMO's model.
- i. A final draft of the Roadmap is attached to this report as Appendix B.
- D. Identification of any other activities necessary for the success of practice transformation efforts, including how the following key practice transformation components will be supported statewide.
- i. Utilizing data in the practice setting for population health management.
 - i. This is a critical core competency for all primary care practices, as listed in the "Practice Transformation Competencies" section of the Practice Transformation Roadmap, and would be a key focus for the assessment and then the practice facilitation for practices participating in the SIM project. The first step in this process involves being able to extract or otherwise obtain the necessary data for patient records and other data sources that would allow the

identification of key populations within the practice and that would collect the information to allow effective management of those populations. As also detailed in the Roadmap, health information support at the practice level, hopefully coupled with centralized data extraction and aggregation services, will be a necessary part of practice support as well.

- ii. Integrating behavioral health and primary care services.
 - i. This is a primary area of focus for the Roadmap and is embedded throughout the document

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APPENDICES

Appendix A – RCCO Practice Transformation Needs Assessment

Appendix B - Colorado State Innovation Model Practice Transformation Roadmap

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Appendix A: RCCO Practice Transformation Needs Assessment

Interview Summary Report

October 15, 2013

Background: From September 19, 2013 through October 7, 2013 the University of Colorado, Department of Family Medicine conducted telephone interviews with the contract managers from 6 Regional Care Collaborative Organizations (RCCO). The purpose of these interviews was to inform the development of a practice transformation plan for Colorado, with a focus on understanding the practice transformation and practice support that is currently provided through the RCCOs and the perceived need for additional practice transformation support for the RCCOs and the practices. The following individuals participated in interviews:

RCCO	RCCO Rep	Counties
1	Rocky Mountain Health Plans Jenny Nate	Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Larimer, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit
2	Colorado Access Dave Rastatter	Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma
3	Colorado Access Molly Markert	Adams, Arapahoe, Douglas
4	Integrated Community Health Partners Donna Mills	Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Lake, Las Animas, Mineral, Otero, Prowers, Pueblo, Rio Grande, Saguache
5	Colorado Access Julie Holtz	Denver (not including Denver Health)
6	Colorado Community Health Alliance Adam Bean	Boulder, Broomfield, Clear Creek, Gilpin, Jefferson
7	Community Care of Central Colorado Kelley Vivian	El Paso, Elbert, Park, Teller

Additional discussions regarding these issues were conducted with Genie Pritchett from Colorado Access and Patrick Gordon from Rocky Mountain Health Plans.

Findings: There are a variety of activities taking place to support primary care practices with practice transformation efforts across the state. Each RCCO has set up practice transformation support based on local resources and needs. Activities include:

- Contract with Health Team Works to provide practice facilitation;
- Contract with CCHAP to provide practice facilitation, along with specific key performance indicator (KPI) support;
- Contract with Physician Health Partners for practice coaching/facilitation;
- Host learning collaboratives;
- Provide quality improvement advisors (through the health plan) to serve as coaches for practices (ex: RMHP practice transformation team works with practices through Beacon, CPCI, Masters Program and Foundations programs);
- Webinars and other sessions to help practices understand the data that is coming out of Statewide Data Analytics Contractor (SDAC);
- Provide support to practices related to the key performance indicators and support for outliers;
- Monthly newsletters for hospitals, specialists and PCMPs;
- Within the RCCOs some practices are already engaged in some kind of practice transformation work. For example, most Community Health Centers were already engaged in practice coaching and had systems or plans in place to address community needs and integrate care;

Barriers/Needs:

Clinician Reluctance:

- Some physicians don't believe that the Affordable Care Act and associated changes are here to stay;
- The biggest barrier is that there is no requirement to do practice transformation. Until the State requires it for incentive payment, some practices won't engage;
- Practices already engaged in PCMH efforts say that the reimbursement has been too low, and practices realize there are burdens to PCMH/transformation that are not paid for;
- In some smaller communities, the RCCOs are seen as outsiders. "We can't make them take our help." (We heard this from most RCCOs, who also indicated that a system that

provided local sources for support tailored to the needs of the community would likely be more effective.)

BH/MH/SA:

- We heard consistently that the #1 unmet need of the RCCOs and the practices is for behavioral/mental health/substance abuse services. There appears to be a lot of awareness among the clinicians of this need.
- Delivery of high quality mental health services is a huge hole in rural communities, with lack of a trained workforce cited as the main barrier.
- There is a large cost associated with getting mental/behavioral health providers embedded in a practice, with practices paying a lot up front to do that. As an example, in one community there is a small practice with 1,000 Medicaid clients that wants to have an embedded MH provider, but the practice indicated that it would need 10s of thousands of dollars to get started.

Practice Transformation:

- Several identified small, often rural practices that are delivering high quality care, yet have not engaged in PCMH, EHR or any kind of transformation activities. The RCCOs have not pushed those practices aggressively because of the overall quality of care that they provide. However, the practices have not implemented portions of the model that would likely help improve care and provide additional population management services, and without better data regarding overall population-level care, the practices are unlikely to perceive a need to change.

Money:

- If the RCCOs take a physician out for a daylong meeting, it results in lost revenue for a practice. Financial reality dictates that practices need support to participate in transformation work. Fee for service is driving practices to focus on revenue, not outcomes.
- Financial incentives are needed to move those providers who are not ready to change. The early adopters are already changing, but financial incentives are needed to get the rest.

- The incentives are not structured correctly, and there is a need to create avenues for complex care management.

Time:

- Just getting practices up to speed with understanding RCCO takes about 40 hours.
- Practices are feeling overloaded with all of the changes taking place.

Capacity:

- As practices accept that this is the future, there will be more demand for services. Penetration with providers has been pretty minimal. They may not all sign up with RCCO, but they will still need support. There will be more work than anyone can handle, and the RCCOs will need additional resources to provide the necessary support.

HIT and HIE:

- There is a strong need to support data sharing. Most stated that practices are waiting for CORHIO to provide long term solutions, and they are piecing together solutions in the meantime. As one RCCO Manager put it, “there is a huge gaping hole” in our ability to share health information.
- There has been no guidance from HCPHF on what information is OK to share among partners (in bringing on dual eligibles). RCCOs need help with getting the data and getting people to agree to share the data.
- Some are struggling with ER utilization data and are working with hospitals to get data on when RCCO clients show up at the ER. This requires both communication channels and a willingness of the hospitals to provide the data.
- SDAC data is like drinking through a firehouse. The RCCOs are providing support to practices to understand their data and how they compare, but the need for practice support in understanding and using the data exceeds the capacity across the state.
- There are some practices with no EHR – either because can’t afford it, or they just don’t want to change.
- Practices that are part of hospital districts are doing better with HIT/EHR. A lot of them buy IT services from the larger system, although the data availability can still be suboptimal.

- CORHIO is expensive and is keeping smaller players out of the field.
- Some RCCOs are hung up in data sharing because of stringent interpretations of HIPAA.

How could an Extension Service help?

- There are some areas of the state where rural providers are isolated, and don't reach out. Extension can build a hub of support with local contacts.
- The practices need to have someone they know is there for them, looking out for their best interest. There is a real mistrust among providers. If anything negative happens with the state, like a provider audit and financial penalty, it spreads like wildfire and deteriorates trust.
- As stated above, there is already tremendous need for practice transformation resources, and the need is going to increase. The availability of an Extension Service would help in the organization, coordination, and provision of practice transformation resources.

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Appendix B

Colorado State Innovation Model Practice Transformation Roadmap

Practice Transformation Introduction and Background

Over recent decades and until recently, the health care payment system increasingly rewarded volume of procedures and in-person visits and carved out reimbursement for the provision of mental health services. This and related developments in the health care system supported a diminution of primary care toward a model that emphasized management of acute problems, de-emphasized coordination of care, and produced barriers to adaptations to improve care for mental and behavioral health issues and to accommodate to the longitudinal, prospective, population-based nature of chronic illness care.¹⁻⁴ The Chronic Care Model (CCM), the Patient Centered Medical Home (PCMH), and other, related models for primary care were developed to address this problem through improved systems of team-based, coordinated care.¹⁻¹³ For large scale health care system redesign efforts such as the Colorado SIM project to be successful, primary care practices have to undertake extensive remodeling and transformation. Research and evaluations of the multiple primary care practice transformation projects currently underway in Colorado and elsewhere have conclusively shown that practice transformation is very difficult and takes longer than expected.¹⁴⁻¹⁷ While practices can accomplish such things as certification or recognition as a patient-centered medical home through an intensive process over a relatively short period of time (perhaps six months to a year), many or possibly most of those practices have not truly transformed in a meaningful or sustained manner that produces the impacts on cost, quality, and experience of care that are needed.^{14,18} Although definitive data is lacking, the impact is greatest in practices that have gone further with a transformation process that includes higher levels of patient engagement and team-based care and have undertaken integrated mental and behavioral health services.¹⁹

A second major and consistent finding in studying ongoing practice transformation efforts is that outside organization and support of the transformation effort can be extremely helpful.¹⁹⁻²² The availability of effective tools and models and enhanced resources do not assure their successful implementation.²³⁻²⁶ Primary care practices are experiencing multiple pressures to see a large

number of patients, to provide improved care, and to do so with often constrained fee-for-service reimbursement. Practices have few mechanisms for the incorporation of new programs, which can exert major pressures on practice operations – even small changes can have substantial consequences that limit their effectiveness.²⁴⁻²⁷ Furthermore, few have adopted ordered and consistent models for practice improvement. Adoption and implementation of new care programs vary across practices based on practice characteristics, including practice culture and change capacity, practice size, rural vs. urban, previous change experience, and decision-making style.²⁸⁻³⁰

Multiple strategies have been used to assist practices in transformation efforts, including practice facilitation, academic detailing, “collaboratives” of practices meeting regularly to share learnings, financial incentives, and other approaches.^{19-23, 29-44} Practice facilitation has particularly emerged as a key method for assisting practices in implementing organizational changes.^{20, 40} Facilitators can assist practices in implementing evidence-based programs, tailoring programs to individual practice situations, improving incorporation of programs into practice operations and increasing sustainability. Consistent evidence supports that practice facilitation can be successful in improving preventive care and implementing the CCM and the PCMH.^{20-23, 30-44} Health information technology barriers to extracting and maintaining registry and other data from health records continues to be a major problem for practice transformation efforts, and on the ground technical support for practices in these efforts can be crucial.⁴⁵ Collaboratives that involve ongoing meetings of representatives from practices working on a common project for training and sharing experiences have also been used extensively in practice transformation efforts.³¹⁻³⁵ Although the effectiveness of standalone collaboratives have been questioned, particularly because of the difficulties of the practice representatives in making changes once they return to their practices, collaborative learning sessions have been very effective when used in conjunction with practice facilitation. Due to the cost of transformation efforts for practices⁴⁶⁻⁴⁸ and the benefits of the results of their transformation efforts to insurers and patients, incentives have been used effectively in assisting and motivating practices to change.²⁹⁻³⁰ An approach that combines multiple methods tailored to fit the targeted changes and the practice characteristics and baseline capacity works best.²⁸

Primary Care Extension Service

Section 5405 of the Affordable Care Act authorizes the establishment of a “Primary Care Extension Program” that would “provide support and assistance to primary care providers to educate providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such matters into their practices and to improve community health by working with community-based health connectors (referred to here as health extension agents).”⁴⁹⁻⁵¹ This model built on the agricultural cooperative extension service, which modernized American agriculture through the dissemination of innovation by using local change agents in every county, with whom farmers developed a trusting relationship.⁵² The agricultural extension agents are linked to a regional hub at a land grant university, a resource for research evidence on best practices and promising innovations. Agricultural extension agents and farmers work collaboratively to solve problems, with the primary source of support local, based on trusting interpersonal relationships. The Health Extension Service is similarly designed, with a central hub of collaborative organizations providing a variety of practice support services linked with the health sciences center and public health organizations. This hub provides organization and resources for health extension agents deployed on a community level. Through ongoing relationships with primary care practices, other health care providers, community agencies, and public health officers and with the connection to the central hub of services, the extension agents could assist practices through technical assistance in the implementation of aspects of the CCM or PCHM, develop partnerships and make practice changes for integrated behavioral health, and implement other, similar innovations. Extension agents could facilitate training for team-based care, with greater focus on population management, patient education, and integrated behavioral health care. The service could also provide technical assistance in the extraction of data from EHRs, provide standardized feedback to clinicians for continuous improvement, and coordinate comprehensive health data collection. Extension agents would assist practices in engaging patients as partners and link practices with public health departments, mental health agencies, local school districts, and other community resources. Links with academics would help disseminate evidence, assess the process of implementation, and involve community clinicians in the generation of new knowledge.

Colorado Health Extension Service

Ongoing meetings of key stakeholders from the Department of Family Medicine of the University of Colorado School of Medicine, the Center for Improving Value in Health Care, the Colorado Area Health Education Center, Health TeamWorks, Rocky Mountain Health Plans, the Colorado Department of Public Health and Environment, the Colorado Department of Health Care Policy and Financing, and other organizations have resulted in a partnership for the formation of a Colorado Health Extension Service. Its mission is improve health and health care across Colorado through: 1) supporting improvement and innovation in primary care practices, 2) improving primary care practice readiness for new payment models through technical assistance and infrastructure development; 3) promoting local collaboration among primary care practices, other health care providers, community groups, patient advisory groups, local public health officers, and public health agencies; and 4) facilitating local or regional efforts to improve health care to meet the Triple Aim. The Extension Service will be a statewide network that gives practices the tools and resources they need become more comprehensive medical homes, implement behavioral health integration, and participate and thrive in the medical and public health neighborhoods of tomorrow. The Extension Service will also support practices with research and data to facilitate their success in the integrated delivery systems taking shape. This vision would be operationalized through a collaborative central hub of support services that will be deployed at the local level through community-based health extension agents. The extension agents serve a critical communication and convening function, bringing together local providers (primary care, behavioral, hospital), public health agencies, community organizations and other key stakeholders to plan and implement improvement efforts. This hub is not designed or intended to compete with existing groups, but rather to complement, coordinate, and provide centralized resources to enhance existing services while filling gaps in services. Our Colorado effort is partnering with similar efforts in Oklahoma and New Mexico to share tools, resources, and experiences and to explore what can be accomplished on a regional basis.

Practice Transformation History and Resources in Colorado

Colorado has had several organizations assisting practices in primary care practice transformation efforts over the past two decades, providing a good start toward the necessary

practice changes for this and related programs. The Clinica Campesina community health center was an early pioneer in this area, as one of the early participants in the Institute for Healthcare Improvement's "Breakthrough Series" collaboratives. Other practices were part of a variety of initial projects to implement aspects of the chronic care model through our state's practice based research networks and other organizations. An early collaborative based on the breakthrough series model was sponsored by the Colorado Foundation for Medical Care quality improvement organization. The Improving Performance in Practice project, aimed at implementing the chronic care model for improving diabetes and/or asthma care, was a national project that used Colorado as one of its two pilot states beginning in 2006, with the Colorado Clinical Guidelines Collaborative (whose name was later changed to HealthTeamWorks) serving as the convener. Through that project and the subsequent, ongoing PCMH Foundations project HealthTeamWorks has provided practice facilitation and collaborative sessions to almost 200 practices. An early multi-stakeholder PCMH demonstration project involving 16 Colorado practices was also convened by HealthTeamWorks, with great results. HealthTeamWorks has also developed a Coach University for training practice facilitators, utilized by multiple organizations from Colorado and across the United States. Rocky Mountain Health Plans has supported multiple practices on the Western Slope in transformation efforts for many years, one of the key reasons behind the successes that have led to that region being singled out as a great exemplar in providing high quality and low cost care. The Colorado Beacon Consortium project led by Rocky Mountain Health Plans and Quality Health Network particularly assisted practices and the Western Slope region in Colorado in developing increased capacity to extract, share, and use patient- and population-level data to improve health care in the region. The Colorado Rural Health Center has supported rural health centers in Colorado through multiple projects, and the Colorado Community Health Network has provided transformation assistance to the community health centers of Colorado. A variety of other organizations, including quality improvement departments of practice organizations such as Physician Health Partners and Kaiser Permanente Colorado, have also provided support for quality improvement and change projects. The Practice Innovation Program of the Department of Family Medicine of the University of Colorado School of Medicine has provided practice transformation support both directly to practices and indirectly through providing training, assessment tools, and evaluation services to many of the efforts listed

above. Particularly relevant to this SIM proposal is the Advancing Care Together (ACT) project that supports 11 innovative practices in behavioral health and primary care integration efforts.

Colorado Medicaid's Regional Care Collaborative Organizations have provided some practice transformation assistance as part of their scope of work. Each RCCO has set up practice transformation support based on local resources and needs. Interviews with the contract managers of the RCCOs from all seven regions indicated some consistent patterns of need, with behavioral health resources and integration being cited repeatedly. They have often had difficulty in engaging practices in transformation efforts. In particular, many rural providers are isolated, don't reach out, and are somewhat distrustful of outside assistance, although this pattern is also seen in urban and suburban practices. The contract managers were very supportive of an extension model, with local contacts who can build ongoing relationships with practices and engage them in practice transformation approaches and services tailored for their needs. The RCCO contract managers indicated that there is already tremendous need for practice transformation resources, and the need is going to increase. The RCCOs are struggling to meet the needs, and the availability of an Extension Service with close relationships with the RCCOs would help in the organization, coordination, and provision of practice transformation resources. While all of these efforts have greatly assisted in preparing Colorado primary care practices for this project, there still is a great deal of practice transformation work to be done. Data regarding the number of primary care clinicians and practices and the current status of their practice transformation efforts are difficult to obtain, with disparities between the various data sources. However, using current definitions of primary care providers that include general internists, primary care pediatricians, family physicians, geriatricians, and nurse practitioners and physician assistants in primary care practices, there appear to be approximately 4,800 primary care providers and 1,500 primary care practices in Colorado. According to the NCQA website, at this time 139 Colorado practices have received NCQA recognition for PCMH. Approximately 150 practices have participated in Health TeamWorks practice transformation projects to the point of reporting quality measurement data, and 51 practices were part of the Colorado Beacon Consortium project. However, some of these practices are included among the practices already receiving PCMH recognition, and many of the others have done only initial stages of practice transformation. Most practices that have worked on PCMH and related practice transformation

have not yet tackled behavioral integration and will need further, tailored support for that work. This will require an organized effort involving multiple organizations, built on a statewide Health Extension Service framework. The next sections will describe the transformation work that will need to be done and provide a detailed description of the approach.

Practice Transformation Competencies

Comprehensive Primary Care Competencies

With the practice transformation and quality improvement projects mentioned above, many Colorado primary care practices have had at least some exposure to aspects of the Chronic Care Model and PCMH. Practice transformation for behavioral health integration is only successful when built on previous transformation to accomplish comprehensive primary care. While the Colorado SIM proposal is not focusing on all of the aspects of the PCMH model and is not requiring PCMH recognition, certain elements of the model are necessary for practices to accomplish the Triple Aim, to provide comprehensive primary care services, and to be prepared to move on to behavioral health integration. These elements include:

1. **Leadership and Practice Engagement** – Multiple projects have identified practice leadership as being a critical factor in determining the success of practice transformation projects. The development of a shared vision for practice transformation with alignment of that vision across internal practice leaders (and hopefully with major external stakeholders, if the practice is part of a larger health system) is a very important part of the transformation process. Everyone in the practice should understand the vision and how their role contributes to the accomplishment of the vision. Effective practice leadership for change usually involves a less hierarchical shared leadership style, engaging and empowering staff members and clinicians throughout the practice as active participants in the change process.
2. **Quality Improvement Process** – In order to transform care processes to provide higher quality care, practices need a team-based process that engages everyone (in smaller practices) or representatives of all key roles within the practice in regular (generally at least twice a month) meetings using effective QI tools. This enables practices to make changes in work flow and protocols that are necessary for implementing new models of care.
3. **Data Capacity** – The successful implementation of comprehensive primary care and integrated behavioral health models is dependent on the availability of specific population

and quality measurement data, including registry functionality. Most EHRs lack key tools and resources, and data extraction is often very challenging. Practices need to determine how to maximize their current electronic or paper resources in order to obtain the data necessary for population management, quality improvement, point of care decision support, and other key functions. They then have to operationalize workflows to maintain current, accurate data and use it to inform quality improvement efforts.

4. Population Management - Provision of services to the entire population of a practice's patients and not only those presenting for care is a central part of comprehensive primary care. Using information systems such as registries to identify sub-groupings of patients with particular chronic conditions or needing particular preventive services can be vital in enabling management of those groups of patients. This allows the identification of and outreach to patients needing an office visit, lab work, care management, or other services. For high risk conditions and situations, it allows targeted care management contacts between visits. This also identifies groups of patients who might benefit from group visits or referral to various community agencies for support or self-management activities.
5. Patient Engagement – True practice transformation requires engaging patients as partners, both in the design of the transformed practice and in the patients' management of their health. Patients have often been passive recipients of care rather than engaged as the active managers of their own care. Patient self-management support requires a shift for clinicians, patients, and practices toward viewing the patient and family as the experts in the day-to-day management of their health. It goes beyond typical patient education and works at the level of providing resources and supporting patients in action planning and building health management skills. In this model, patients and family members fully participate through shared decision making in the development of goals, priorities, and action plans for care. The resulting personalized care plans are then used by everyone in the care team, including outside consultants, in coordinating and providing care. Effective self-management support can particularly help patients with chronic conditions cope with the challenges of living with and managing their illness, as well as providing the necessary support for all patients in maintaining healthy lifestyles.
6. Team-based Care – Another very important part of the patient-centered medical home and other comprehensive primary care models involves increasing the use of advanced team

approaches to care, training and empowering members of the staff to work to the highest level of their knowledge, skills, ability and licensure. A multi-disciplinary team approach creatively uses the different skill sets within the practice to collectively share responsibility for meeting patient and family needs, with clearly defined roles. This necessitates understanding the roles and abilities of each individual and the functions they provide, as well as providing training to reliably take on new tasks and responsibilities. The initial establishment of team structures, culture, and workflows is necessary to enable the more complicated addition of behavioral health professionals as part of the team.

7. Coordination of Care – Effective comprehensive primary care requires coordination of patient care activity across the extremely complex health system, the practice, and the patient’s family and community. From the patient’s viewpoint, care should be as seamless as possible, derived from a personal care plan collaboratively developed by the patient, family, primary care clinician, and other practice staff and then communicated to anyone involved in the care of the patient. Coordination of care is dependent upon reliable, efficient, and effective communication systems across disciplines within the health care system in a way that benefits the patient and remains patient-centered. Careful coordination of care improves handoffs from one part of the care system to another and prevents unnecessary services, errors in care, and deficient follow-up on key care issues. Engagement of the other health partners in the community by the primary care practices will be necessary to assure the appropriate level of care coordination.

Behavioral Health Integration Competencies

From multiple experiences it is apparent that successful behavioral health integration is challenging, even for practices that have already successfully accomplished the necessary transformation described above. The practices attempting behavioral integration require support for further transformation in some key areas, as described below.

1. Screening – The identification of patients with behavioral issues or difficulties in managing their health conditions depends on the implementation of evidence-based screening protocols. Without such systematic screening, most behavioral issues go unidentified and unmanaged.
2. Systematic Follow-up – Screening to identify behavioral issues is worthless and potentially harmful unless coupled with a reliable system to manage those patient issues that are

identified. This involves the development of new workflows that involve multiple people within the practice. These practice systems have to include assurance of ongoing monitoring of patient progress.

3. **Expanded Team Approach** – Behavioral health integration depends on a team-based approach, with commitment from everyone to a vision of whole patient care provided by an enriched inter-professional team. Behavioral clinicians bring a new approach to care to the team, with different training, cultural norms, and clinical models. The ability of the team to successfully incorporate the new clinicians and approaches into the team and build a new, integrated approach to care in the practice determines the success of such efforts. This requires a careful discussion of roles and responsibilities and leads to the development of new approaches to care for both the practice and the behavioral professionals.
4. **Transitions and Handoffs** – One of the great benefits of having integrated behavioral health in the practice is the ready, immediate availability of such services to patients who would otherwise be unable or unwilling to follow-through with outside referrals. It is clear that a “warm handoff” of patients from the primary care clinician to the behavioral health clinician makes behavioral care more acceptable and accessible for patients; it becomes just another part of the services provided by the practice instead of a major transition of care that has multiple barriers, including stigma. The behavioral clinician can also work to ease the transition to more intensive or specialized behavioral services outside the practice when necessary. The careful development of workflows and language around these handoffs and transitions is crucial.
5. **Data Systems** – Integrated systems of care have particular challenges for data systems. Behavioral health clinicians typically have a more narrative format for their records that may not fit the EHRs used by the primary care practice. Narrative data causes difficulties in data extraction for registries or quality improvement. Data regarding mental health, substance use, and other psychosocial issues also have to be handled carefully and sometimes differently from other health care information to assure patient privacy. Regardless of these barriers, it is crucial that the important clinical information and personalized care plans be shared by the primary care and behavioral clinicians; otherwise, truly integrated care cannot be accomplished. Integrated care presents additional opportunities for the identification and management of high risk or high need patients in the practice’s population, a key aspect of

accomplishing improved care and lower overall health care costs. In addition, linking patients' clinical and behavioral health records to other data sources such as claims data or public health records will be valuable to refine population management efforts and allow monitoring implementation and assessing the effects of the SIM project.

6. Community Partnerships – While not specific to practices with behavioral health integration, the process of integration and further building on the principles of self-management support leads practices into a need for partnering with public health and community agencies that can provide resources to assist patients in the management of the health and in health behavior changes. This often leads to a broader partnership among primary care practices, public health, and community groups to improve community health.

Practice Transformation Plans for the SIM Project

Necessary Framework and Structure

A major, statewide care transformation effort such as the Colorado SIM project requires a coherent shared vision and model for transformation, the development of resources to support the transformation, and the coordination of the providers and the provision of support services. A statewide framework such as the Colorado Health Extension Service will be necessary in order to accomplish these tasks. The Extension Service would maintain a central hub of resources and triage the provision of support services, generally by using existing practice support organizations but in some cases directly providing services as necessary. It is important to note that local or regional features and circumstances strongly influence the practice transformation process, and any statewide framework or model must maintain the flexibility to adjust to local conditions. The Extension Service would at least strongly interface with the Medicaid Regional Care Collaborative Organizations (RCCO) in order to coordinate and assist with their needs, and regional hubs based on the RCCO framework might be desirable. However, practice transformation, like most things in health care, is all about relationships. The ongoing relationship of the practices with an extension agent at the local community level can provide a go-to resource for practices to access the support services needed for their individual stage of transformation. The services to be provided by the statewide extension service would include the following:

1. Practice Education - Educational sessions regarding the vision, context, and specific components of the Colorado SIM project could be provided through academic detailing at the

practice, during gatherings of multiple practice representatives at the local level, or made available online through both recorded presentations and interactive e-learning modules.

2. Leadership Development - The educational sessions described above would be a start toward leadership development, but specific consultation with clinician and management leaders will also often be necessary in order to attain alignment with the vision of the SIM project. This will likely involve mostly in-person meetings with extension agents or other extension service staff, sometimes with participation by opinion leaders from the community.
3. Links to Practice Facilitation – As described above, practice facilitation has been shown to be a very important element for any practice transformation effort, serving as an external source of support, expertise, encouragement, and accountability. Two related but separate levels of practice facilitation will be needed: a) preparation for behavioral health integration, implementing critical comprehensive primary care or PCMH elements that need to be in place both as part of a comprehensive approach to enhancing primary care and as foundational preparation for integration, and b) advanced facilitation to accomplish behavioral health integration. Practices will be staged through an initial assessment as described below and matched with the appropriate type and level of facilitation. Some practices already have an existing relationship with a particular organization for facilitation, and those relationships will be preserved whenever possible. The extension service will be responsible for triaging and coordinating practice connections with practice facilitation providers, training and providing resources for the practice facilitators for behavioral health integration, evaluating the practice facilitation, and sharing best practices across practice facilitators and practice support organizations.
4. Learning Community – Forming a learning community of practices, sharing experiences regarding their transformation efforts, will also be an important part of this practice transformation effort. This will be accomplished through several methods, including: a) regular regional collaborative meetings of practices working on transformation, b) regular webinars or conference calls covering specific topics, and c) using the extension agents and the practice facilitators to arrange cross-practice consultations and/or visits. The regional collaborative learning sessions will occur three times a year, typically running on a six-hour, midday schedule to allow multiple practice personnel to participate without overnight travel expenses. All practices will be encouraged to participate in the collaboratives and other

learning community activities, regardless of their level of readiness (described below) or engagement in other practice support activities. Webinars will be scheduled on a monthly basis, planned in consultation with the extension agents and practice facilitators based on practice needs.

5. Data Extraction and Management – This is an area of major concern, as the absence of effective data extraction and management capacity could greatly limit the success of the SIM project and other related practice and health system transformation efforts. The Colorado Comprehensive Primary Care Initiative recently released an invitation for proposals for data aggregation services that would help CPC practices achieve the milestones of the CPC Initiative, identify shared gains or losses within and across payer programs, foster shared learning, and “create a statewide health information network that aligns with existing community resources, grows, and is sustainable beyond the scope of the CPC Initiative” That initiative established a proposed launch target of July 2014 to provide practices with initial reports that will provide administrative data cost, utilization, and benchmarking metrics. The primary objectives for that initiative are as follows:
 - a. Centralizing reporting for prioritized payer data: same time, same place, same format
 - b. Creating and maintaining a “person view” across multiple carriers, regardless of coverage and enrollment changes (i.e. metrics produced will follow the person continuously, regardless of changes in coverage status or health plan enrollment)
 - c. Implementing universal metrics for ranking, benchmarking, and longitudinal analysis
 - d. Reporting and analyzing the total cost of care
 - e. Streamlining the secure production of agreed to “raw” data elements in a standardized format for consumption by existing practice registries and and/or related clinical analytic tools
 - f. Producing credible comparative analysis
 - g. Supporting productive alignment of individual payer programs and initiatives
 - h. Creating a basis for continuity when member enrollment changes (for attribution, risk adjustment, care coordination, and other purposes)

The CPC initiative also established longer term objectives, beyond the scope of the initial, administrative data use cases described above for the July 2014 release, with the belief that creating architecture for the integration of additional data sources and support for more

sophisticated clinical, analytic and population health management is critical to the success of the practices in the CPC. These objectives include:

- Clinical Data - The extraction and structuring of clinical data sets from physician, hospital and ancillary service systems for defined measurement and application use cases
- Patient-Reported Data - Support for the collection and structuring of patient-reported data, via a variety of encounter and non-encounter based modalities, from emerging screening, assessment and survey tools.
- Public Reporting - Support for efficient, value-adding community alternatives for the public reporting of clinical process and outcome measures-- beyond the scope of current, single-practice, EHR-based mechanisms.
- Robust Identity Management - Integration of scalable tools that can support complex data matching and vocabulary management functions across diverse data sources
- Physician Workflow Integration - Integration of the data and applications within established clinical platforms, with minimum disruption to efficient workflows and cumbersome authentication requirements.

The text above, drawn almost exclusively from the Colorado CPC Aggregated Data Solution invitation for proposals, describes exactly the type of data aggregation, analysis, and reporting capacity necessary for making the Colorado SIM project a success. While the establishment of this type of data aggregation, analysis, and reporting capacity extends far beyond the practice transformation aspects of this project, the lack of this type of data capacity has been one of the biggest barriers to our practice transformation efforts to this point and will continue to be a barrier unless this is resolved. If the CPC effort is successful, it could provide a platform that could be further extended in the SIM project for the benefit of the statewide health care system. However, regardless of these data aggregation efforts, the practice transformation effort for SIM will have to include technical support from on-the-ground health information technology consultants to assist practices with building their data extraction and management capacity in order to be successful their transformation process. The model used in the Colorado Beacon Consortium and other practice transformation efforts by Rocky Mountain Health Plans for deployment of these HIT consultants to work alongside practice facilitators has been very successful and should be followed in the SIM project.

6. Patient Engagement – Patient advisory groups or patient participation on improvement teams can be extremely helpful for practice in making sure that their efforts are both transformational and patient-centered. Practices often need assistance in establishing patient advisory groups. The extension service will provide centralized resources as well as training of the local extension agents to provide this assistance. Practices engaged in active support through the SIM project for their practice transformation efforts will be strongly encouraged to form and maintain patient advisory groups.
7. Community Engagement – As practices move into population management, patient self-management support, and behavioral integration, the need for engagement with community agencies and public health for certain types of patient services becomes very evident. The extension agents will assist in connecting practices with the appropriate community services. As the project progresses, the extension agents also will provide a vital community-level convening and engagement function, bringing together community primary care practices, behavioral providers, other health care providers, local public health officers, community agencies, and others to provide more coordinated health care to the population and to work on improving community health.
8. Linkage to Community Health Workers – Trained lay community health workers have increasingly been used to provide a variety of health-related services on a community level and can be an important way of linking public health and primary care practices. Rocky Mountain Health Plan, as part of its State Innovation Model work, is developing a model for training and deploying community health workers. In New Mexico and other states with extension services, community health workers are trained and to some extent deployed through the extension service, and a similar function is anticipated in Colorado.
9. Engagement of the Behavioral Health Community – From a business perspective, there are three ways for practices to bring a behavioral provider onto their staff. They can 1) hire a behavioral provider as an employee, 2) contract with a community mental health center, or 3) contract with a private behavioral group. With pros and cons for each, a key issue for practices working on behavioral integration will be exploring the options available locally and making decisions regarding how to proceed. The extension service will work with mental health centers to develop their capacity and management structures for creating relationships with primary care practices. This will need to involve mental health center partners such as

Jefferson Mental Health Center, which has done pioneer work in this arena. Similar work will need to be done with the private/independent behavioral health community. Since the clinical model for behavioral professionals is quite different in primary care settings, training programs, some virtual, will need to be made available. On the local level, extension agents will assist in identifying potential behavioral partners and engage the behavioral community in working on this important issue.

10. Practice Preparation for New Payment Models - Moving into behavioral integration and corresponding new payment models involves preparing for a new business model for primary care practices. Education and assistance will need to be provided for developing partnerships with behavioral providers (sometimes through contracts with behavioral organizations such as community mental health centers) and other partners. Practices also need to be prepared for a move from fee for service to global payment frameworks, with performance standards and possible share savings and shared risk. The development of these competencies will need to proceed while practices are moving into comprehensive primary care and behavioral integration.

Practice Transformation Process

The preceding section describes the necessary components and structure of a statewide practice transformation effort. This section describes the process of working with practices to accomplish the necessary transformation. A diagram of this process is attached as Figure 1.

Practice Assessment – The first step in this process is an assessment of practice readiness. The assessment will proceed in two stages. The first stage is an online practice information form that covers practice demographics (size, type of practice, location, population served), EHR and data reporting status (including meaningful use), PCMH implementation, and quality improvement experience. This assessment will be used to help stage practices according to their projected initial readiness to implement behavioral health integration. Practices that appear to be highly ready for behavioral health integration will be prioritized to receive the second stage of the assessment, which will consist of an in-person (or if necessary, phone) interview by the local extension agent and completion of the Comprehensive Primary Care Practice Monitor (attached as Appendix 1). The Monitor assesses key elements of practice transformation listed above for both comprehensive primary care and for behavioral health integration itself. Based on the information gathered from the two-stage assessment, practices will then be categorized as 1) high

readiness for behavioral health integration, 2) low to moderate readiness, or 3) very low readiness or not willing to proceed at this time.

Practice Transformation Assistance

The plans for support for each practice will then proceed according to the three readiness categories based on the assessment.

1. High Readiness – Practices in this category will have a high level of implementation of the basic PCMH/comprehensive primary care elements listed above, assessed through the Monitor. They will have a vision that is aligned with behavioral integration and may have taken some steps toward its implementation. These practices can be targeted for practice transformation support early in the rollout of the SIM project, should be able to implement behavioral health integration and move toward advanced payment models relatively quickly, and will provide initial successes, lessons learned, and best practices to guide the ongoing practice transformation efforts across the state. Depending on the details of the assessment, they will need a combination of: a) further practice education regarding behavioral integration, b) assistance with identifying behavioral health partners, c) assistance with the business aspects of implementing behavioral health and/or moving toward advanced payment models, d) practice facilitation specifically aimed at the implementation of behavioral integration, and e) HIT assistance regarding new areas of data extraction for QI and or population management, implementation of a personalized care plan within their record systems, and/or dealing with barriers to sharing medical records across behavioral and primary care clinicians. Depending on the deployment of community health workers in the community, they also could benefit from coordination with those efforts as well. These practices would be actively included in local meetings convening public health, behavioral health, community resources, and other local health providers in the formation of “communities of solution” to work on local health and health care problems. We would anticipate that approximately six to twelve months of active practice facilitation and other related in-practice support would be needed by most practices at this stage, with intermittent check-ins and targeted consultations after that. Throughout the term of the project, these practices would benefit from ongoing participation in learning community activities, including the regional collaborative learning sessions, where they could serve as both learners and as sources of practical lessons learned for other practices that will follow behind

them in their behavioral integration efforts. Based on our best estimates of the current status of practice transformation in Colorado, we would anticipate that approximately 10% of the practices in Colorado will fall into this category. This will include most of the federally qualified health centers and other practices that have achieved PCMH recognition. In particular, the 74 practices participating in the Comprehensive Primary Care Initiative have the background and ongoing activities that should prepare them well to move fairly quickly into behavioral integration.

2. Low to Moderate Readiness – These practices will have moved toward implementation of some of the basic comprehensive primary care elements and will have at least an initial vision and readiness to move toward behavioral health integration. Many of these practices will need HIT assistance, and all will require practice facilitation. The model for practice facilitation for these practices will focus on achievement of the basic comprehensive primary care elements, but with some ongoing focus on behavioral integration. Data management and population management skills will be a particular focus for their training, along with the other comprehensive primary care competencies listed above. As these practices approach readiness for behavioral integration, the other resources and activities listed for the high readiness practices will be introduced, as coordinated by the local extension agent in partnership with the practice facilitator. Some of the practices may decide to engage a behavioral clinician during this preparatory phase in order to accelerate their inclusion on the team and involvement in these earlier practice transformation activities. During the entire period of the project, the practices would be expected to participate actively in the regional collaborative learning sessions and other learning community sessions as described above. They also would be provided with engagement with local community health workers and have initial training regarding new business models at appropriate points in their progression. These practices will take a variable length of time to progress to the stage of true behavioral integration depending on their initial state of readiness, likely ranging from six to 18 months but generally averaging about a year. Based on our best estimates of the current status of practice transformation in Colorado, we would anticipate that approximately 60% of the practices in Colorado will fall into this category.
3. Very Low Readiness or Unwilling – These practices will have done little or nothing to implement PCMH/comprehensive primary care transformation and will have limited data

capacity. They also may be resistant to making these changes and will require focused education and leadership development to move them toward a practice vision of comprehensive primary care and behavioral integration. Much like patients who are pre-contemplative regarding the need for a health behavior change, an ongoing relationship with a change agent (the extension agent in this case) along with education and incentive alignment can provide the necessary impetus and context to accomplish change in resistant clinicians and practices. Practices that become willing but lack basic data capacity will be provided with HIT assistance. All practices will be invited to local collaborative learning sessions, which may help with education and leadership alignment. When the practices are willing to move forward and have a basic level of data capacity, they will advance to the “low to moderate readiness” category as above and receive practice facilitation. Based on our best estimates of the current status of practice transformation in Colorado, we would anticipate that approximately 30% of the practices in Colorado will initially fall into this category, with perhaps half of them eventually becoming willing and ready to move into the middle category described above.

Ongoing Monitoring

Practices engaged in active support will be re-assessed every four months using the Comprehensive Primary Care Practice Monitor, reports on practice engagement from the extension agents and practice facilitators, and, where appropriate, progress with quality data measure reporting and outcomes. This assessment will assist practices and practice facilitators in planning next steps and will gauge practice progress toward achievement of project milestones. Practices making steady progress in accomplishing project milestones will continue to receive tailored support based on their progress. It is anticipated that most practices will need active support by practice facilitators for approximately six to twelve months at each readiness category stage, with subsequent intermittent check-ins by the extension agents to determine the need for further tailored practice facilitation or consultation following that period. For practices that appear to be stalled or not engaged upon re-assessment, a discussion with practice leadership will determine an interim plan for improved engagement for the next four month period. Upon the next re-assessment, a continued lack of progress would result in suspension of in-practice support by practice facilitation until the practice could demonstrate improvement in their ability

and willingness to fully engage in the practice transformation efforts. However, these practices would be encouraged to participate in ongoing learning community activities (such as collaborative learning sessions and webinars) and would continue to receive intermittent visits from the extension agents to encourage their engagement.

References

1. Wagner EH, Austin BT, Von Korff M. Improving outcomes in chronic illness. *Managed Care Quarterly*. 1996 Spring 1996;4(2):12-25
2. Wagner EH. Population-based management of diabetes care. *Patient Education & Counseling*. 1995 Sep 1995;26(1-3):225-230.
3. Glasgow RE, Hiss RG, Anderson RM, et al. Report of the health care delivery work group: Behavioral research related to the establishment of a chronic disease model for diabetes care. *Diabetes Care*. 2001;24(1):124-130.
4. Bodenheimer T, Pham HH. Primary care: current problems and proposed solutions. *Health Aff (Millwood)*. May 2010;29(5):799-805.
5. Wagner EH, Davis C, Schaefer J, Von Korff M, Austin B. A survey of leading chronic disease management programs: are they consistent with the literature? *Managed Care Quarterly*. 1999;7(3):56-66.
6. Wagner EH, Austin BT, Von Korff M. Organizing care for patients with chronic illness. *Milbank Quarterly*. 1996;74(4):511-544.
7. Grundy P, Hagan KR, Hansen JC, Grumbach K. The multi-stakeholder movement for primary care renewal and reform. *Health Aff (Millwood)*. 2010; 29(5):791-798.
8. Rosenthal TC. The medical home: growing evidence to support a new approach to primary care. *J Am Board Fam Med*. 2008;21(5):427-440.
9. American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (AOA). Joint Principles of the Patient-Centered Medical Home. 2007; http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf. Accessed July 17, 2011.
10. Backer LA. Building the case for the patient-centered medical home. *Fam Pract Manag*. 2009;16(1):14-18.

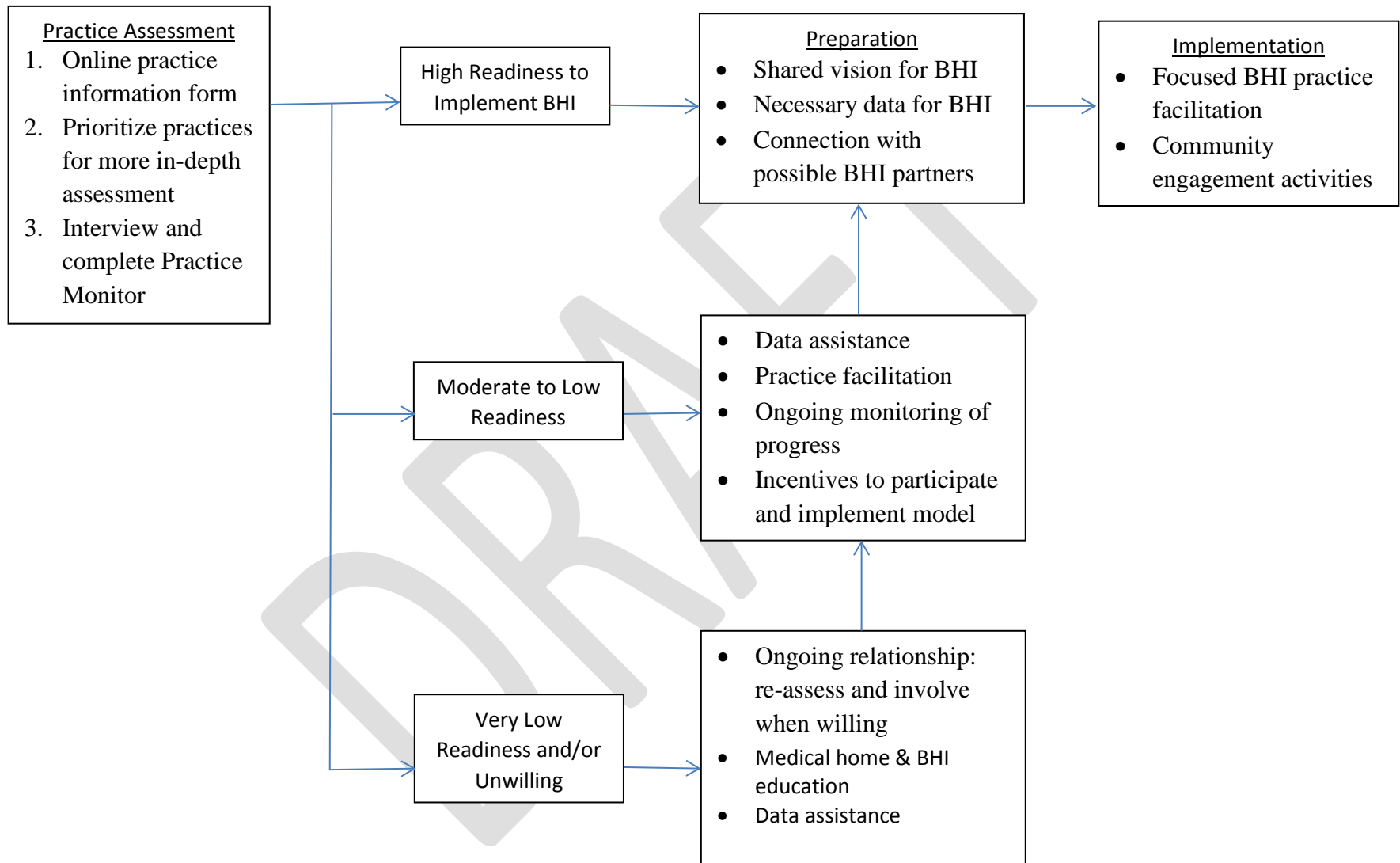
11. Fisher ES. Building a Medical Neighborhood for the Medical Home. *N Engl J Med*. 2008;359(12):1202-1205.
12. Iglehart JK. No Place Like Home -- Testing a New Model of Care Delivery. *N Engl J Med*. 2008;359(12):1200-1202.
13. Grumbach K, Bodenheimer T. A primary care home for Americans: putting the house in order. *JAMA*. 2002;288(7):889-893.
14. Solberg LI, Crain AL, Tillema J, Scholle SH, Fontaine P, Whitebird R. Medical home transformation: a gradual process and a continuum of attainment. *Annals of Family Medicine*. 2013; 11:S108-S114.
15. Scholle SH, Asche SE, Morton S, Solberg LI, Tirodkar MA, Jaen CR. Support and strategies for change among small patient-centered medical home practices. *Annals of Family Medicine*. 2013; 11:S6-S13.
16. McNellis RJ, Genevro JL, Meyers DS. Lessons learned from the study of primary care transformation. *Annals of Family Medicine*. 2013;11:S1-S5.
17. Nutting PA, Crabtree BF, Miller WL, Stange KC, Stewart E, Jaen C. Transforming physician practices to patient-centered medical homes: lessons from the national demonstration project. *Health Affairs*. 2011;30(3):439-445.
18. Clarke RMA, Tseng C, Brook RH, Brown AF. Tool used to assess how well community health centers function as medical homes may be flawed. *Health Affairs*. Published before print, <http://content.healthaffairs.org/content/early/2012/02/13/hlthaff.2011.0908.full>. Accessed 5/16/13.
19. Dickinson WP, Miller WL, Keller DM, Bitton A, Mold JW. Practice transformation: suggested areas for prioritized research. Presented at Patient Centered Medical Home Research invitation meeting sponsored by AHRQ, the Veterans Administration, and Commonwealth Foundation. Washington, DC (2013).
20. Grumbach K, Bainbridge E, Bodenheimer T. Facilitating Improvement in Primary Care: The Promise of Practice Coaching. Commonwealth Fund Issue Brief, Publication 1605, Volume 15 (2012).
21. Dickinson WP, Dickinson LM, Nutting PA, Emsermann C, Tutt B, Crabtree BF, Fisher L, Harbrecht M, Gottsman A, West DR. Practice facilitation to improve diabetes care in

- primary care: a report from the EPIC randomized clinical trial. *Annals of Family Medicine*. In press.
22. Fernald DH, Deaner N, O'Neill C, Jortberg BT, deGruy FV, Dickinson WP. Overcoming early barriers to PCMH practice improvement in family medicine residencies. *Family Medicine*. 2011;43:503-509.
 23. Jaen CR. Successful health information technology implementation requires practice and health care system transformation. *Ann Fam Med*. Sep-Oct;9(5):388-389.
 24. Sittig DF, Ash JS. On the Importance of Using a Multidimensional Sociotechnical Model to Study Health Information Technology. *Ann Fam Med*. September 1, 2011;9(5):390-391.
 25. Baron RJ. Quality Improvement with an Electronic Health Record: Achievable, but Not Automatic. *Annals of Internal Medicine*. October 16, 2007 2007;147(8):549-552.
 26. Baron RJ, Desnoee E. Practice profile. The struggle to support patients' efforts to change their unhealthy behavior. *Health Aff (Millwood)*. May;29(5):953-955.
 27. Tallia AF, Stange KC, McDaniel RR, Jr., Aita VA, Miller WL, Crabtree BF. Understanding organizational designs of primary care practices. *J Healthc Manag*. Jan-Feb 2003;48(1):45-59; discussion 60-41.
 28. Solberg LI, Brekke ML, Fazio CJ, et al. Lessons from experienced guideline implementers: Attend to many factors and use multiple strategies. *Joint Commission Journal on Quality Improvement*. 2000;26(4):171-188.
 29. Davis K, Bialek R, Parkinson M, Smith J, Vellozzi C. Paying for preventive care: moving the debate forward. *Am J Prev Med*. 1990;6(4 Suppl):7-30.
 30. Morrow RW, Gooding AD, Clark C. Improving physicians' preventive health care behavior through peer review and financial incentives. *Arch Fam Med*. 1995;4(2):165-169.
 31. Wagner EH, Glasgow RE, Davis C, et al. Quality improvement in chronic illness care: a collaborative approach. *Jt Comm J Qual Improv*. 2001 2001;27(2):63-80.
 32. Pearson ML, Wu S, Schaefer J, et al. Assessing the implementation of the chronic care model in quality improvement collaboratives. *Health Serv Res*. Aug 2005;40(4):978-996.
 33. Mittman BS. Creating the evidence base for quality improvement collaboratives. *Ann Intern Med*. Jun 1 2004;140(11):897-901.

34. Solberg LI. If you've seen one quality improvement collaborative ... *Annals of Family Medicine*. 2005 May-Jun. 2005;3(3):198-199.
35. Ovretveit J, Bate P, Cleary P, et al. Quality collaboratives: lessons from research. *Qual Saf Health Care*. 2002 Dec 2002;11(4):345-351.
36. Bender BG, Dickinson WP, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado Asthma Toolkit Program: A practice coaching intervention from the High Plains Research Network. *Journal of the American Board of Family Medicine*. 24:240-248 (2011).
37. Nease DE, Nutting PA, Dickinson WP, Graham DG, Gallagher KM. Long-term sustainability of depression care improvements following an improvement collaborative emphasizing practice change. *Journal of the American Board of Family Medicine*. 23:598-605 (2010).
38. Nease DE, Nutting PA, Dickinson WP, Bonham AJ, Graham DG, Gallagher KM, Main DS. Inducing sustainable improvement in depression care in primary care practices: A report from the National Depression Management Leadership Initiative's Improving Depression Care Project. *Joint Commission Journal on Quality and Patient Safety*. 34(5):247-255 (2008).
39. Knox L, Taylor EF, Geonnotti K, Machta R, Kim J, Nysenbaum J, Parchman M. Developing and running a primary care practice facilitation program: a how-to guide. Rockville, MD: Agency for Healthcare Research and Quality;2011.
40. Baskerville NB, Liddy C, Hogg W. Systematic review and meta-analysis of practice facilitation within primary care settings. *Ann Fam Med*. Jan-Feb 2012;10(1):63-74.
41. Stange KC, Goodwin MA, Zyzanski SJ, Dietrich AJ. Sustainability of a practice-individualized preventive service delivery intervention. *Am J Prev Med*. 2003;25(4):296-300.
42. Nagykaldi Z, Mold JW, Aspy CB. Practice facilitators: A review of the literature. *Fam Med*. 2005 Sep. 2005;37(8):581-588.
43. Hogg W, Baskerville N, Nykiforuk C, Mallen D. Improved preventive care in family practices with outreach facilitation: Understanding success and failure. *Journal of Health Services & Research Policy*. 2002 2002;7(4):195-201.

44. Ruhe MC, Weyer SM, Zronek S, Wilkinson A, Wilkinson PS, Stange KC. Facilitating practice change: Lessons from the STEP-UP clinical trial. *Preventive Medicine*. 2005 Jun. 2005;40(6):729-734.
45. Fernald DH, Wearner R, Dickinson WP. The journey of primary care practices to meaningful use: a Colorado Beacon Consortium study. *Journal of the American Board of Family Medicine*. 26:603-611 (2013).
46. West DR, Radcliff TA, Brown T, Cote MJ, Smith PC, Dickinson WP. Costs associated with data collection and reporting for diabetes quality improvement in primary care practices: a report from SNOCAP-USA. *Journal of the American Board of Family Medicine*. 25:275-282 (2012).
47. Gill JM, Bagley B. Practice transformation? Opportunities and costs for primary care practices. *Annals of Family Medicine*. 2013;11:202-205.
48. Culler SD, Parchman ML, Lozano-Romano R, Noel PH, Lanham HJ, Leykum LK, Zeber JE. Cost estimates for operating a primary care practice facilitation program. *Annals of Family Medicine*. 2013;11:207-211.
49. Mold, JW. A Cooperative Extension Service for Primary Care in Oklahoma. *Journal of the Oklahoma State Medical Association*. 2011; November/December:414-418.
50. Grumbach K, Mold JW. A health care cooperative extension service: transforming primary care and community health. *JAMA*. 2009; 301:2589-2591.
51. Phillips RL, Kaufman A, Mold JW, Grumbach K, Vetter-Smith M, Berry A, Burke BT. The Primary Care Extension Service: a catalyst for change. *Annals of Family Medicine*. 2011; 11:173-178.
52. Rogers EM. *Diffusion of Innovations*. 5th ed. New York: Free Press; 2003.

Figure 1: Practice Transformation Support



Appendix 1

Comprehensive Primary Care Monitor

In the tables below consider how fully each item has been implemented or functions in your practice. Fill in the circle that best reflects the completeness of implementation in your practice. If something is completely implemented, it means it is now common and routine across the entire practice.

1. LEADERSHIP & PRACTICE ENGAGEMENT	Not at all Completely ▼ ▼
a. The concepts of comprehensive primary care and behavioral health are understood and actively supported by practice leaders.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
b. Practice leaders support innovation and are willing to take risks and have occasional failures in order to improve.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
c. A culture of shared leadership has been created, with everyone sharing responsibility for improvement in the practice.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
d. The practice has a shared vision for practice transformation that everyone understands and supports.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
e. Opportunities are provided for all staff members to be involved in practice change and improvement processes.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5

2. QUALITY IMPROVEMENT (QI) PROCESS	Not at all Completely ▼ ▼
a. There is a QI team that meets regularly (at least twice a month).	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
b. QI team meetings are well-organized, with agendas, meeting summaries, prepared leaders and members.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

	⑤
c. The QI team uses QI tools effectively – AIMS, process mapping, PDSA.	① ② ③ ④ ⑤
d. QI team members reliably follow-up on assignments and tasks, with good team accountability.	① ② ③ ④ ⑤
e. The QI team has a sustainable, reflective QI process that deals effectively with challenges and conflict.	① ② ③ ④ ⑤
f. Our practice has identified specific clinical conditions for quality improvement.	① ② ③ ④ ⑤
g. Specific quality measures have been chosen for the targeted conditions.	① ② ③ ④ ⑤
h. Quality measures and other data are used as a central area of focus for the practice’s improvement activities.	① ② ③ ④ ⑤

3. DATA CAPACITY	Not at all Completely ▼ ▼
a. The practice has an ongoing, reliable system for empanelment and panel management within our data systems and practice processes.	① ② ③ ④ ⑤
b. We are able to extract data from our medical record systems for registries	① ② ③ ④

(lists of patients with particular conditions and with key information about those patients.)	⑤
c. Clean and accurate quality measurement data are available for targeted conditions.	① ② ③ ④ ⑤
d. Workflows for maintaining accurate registry data have been reliably implemented.	① ② ③ ④ ⑤
e. Quality measures are reported and reviewed monthly.	① ② ③ ④ ⑤

4. POPULATION MANAGEMENT	
	Not at all Completely ▼ ▼
a. Registry data are used to identify specified populations of patients.	① ② ③ ④ ⑤
b. Patients with care or outcomes falling outside of guidelines are identified for more intensive care.	① ② ③ ④ ⑤
c. The practice has a patient recall system designed and implemented to bring in patients for needed care.	① ② ③ ④ ⑤
d. The practice uses a standardized method or algorithm for identifying its high risk patients.	① ② ③ ④ ⑤
e. The practice provides care management services for patients identified as being high risk or needing additional assistance, community resources, and/or contact between visits.	① ② ③ ④ ⑤

5. PATIENT ENGAGEMENT	Not at all Completely ▼ ▼
a. A system has been implemented for identifying and monitoring patient needs for support in health behavior change and managing their chronic conditions.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
b. A system has been implemented for assisting patients with developing goals and action plans for health behavior change and chronic disease management.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
c. Personalized care plans are developed collaboratively with patients and families.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
d. Care plans and action plans are regularly reviewed to monitor patient progress in accomplishing their goals and adjusted when appropriate.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
e. Patients and families are provided with tools and resources to help them engage in the management of their health between office visits.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
f. Patients and families are actively linked with community resources to assist with their self-management goals.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
g. Our practice systematically seeks and uses patient and family input regarding practice transformation and integrated care.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
h. The practice has a system to insure that patients are able to see their own clinician as often as possible.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
i. Patients and families can reliably and quickly access their personal clinician or a care team member to answer questions or deal with problems.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
j. Patients can reliably make an appointment with their personal clinician or a care team member within defined and acceptable time periods.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5

6. TEAM-BASED CARE	
6. TEAM-BASED CARE	Not at all Completely ▼ ▼
a. Care teams have been designated and hold regular team meetings (can be everyone in very small practices).	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
b. Team members have defined roles that make optimal use of their training and skill sets.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
c. Protocols and standing orders have been implemented to better distribute workload throughout the team.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
d. The practice team has received training in integrated care and continuing education about integration and evidence-based practice is routinely provided.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
e. Team huddles are used to discuss patient load for the day and to plan for patient visits.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5

7. COORDINATION OF CARE	
7. COORDINATION OF CARE	Not at all Completely ▼ ▼
a. Local referral sources and community resources are identified and information aggregated in a central location for clinicians and staff to access.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
b. Our practice communicates actively with specialists and community resources to coordinate care based on the patient's personalized care	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5

plan.	
c. A structured system is in place for assuring appropriate follow-up and care planning for patients undergoing transitions of care (such as discharge from hospital, ER visit, etc.).	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
d. When referrals are made to specialists or community resources, key information is communicated ahead of the visit and appropriate follow-up is achieved.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
e. Care coordinators are used to ensure patient connectivity to outside providers and community resources.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5

8. BEHAVIORAL HEALTH INTEGRATION	
<i>Note: "Behavioral health" includes mental health, health behavior change, and substance abuse services.</i>	Not at all Completely ▼ ▼
a. Our practice has a shared vision for behavioral health integration that everyone understands.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
b. Our practice has identified behavioral health conditions for focused quality improvement.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
c. A system has been implemented to screen for patient behavioral health issues.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
d. We have reliable registry data to identify and manage specific populations of patients with behavioral health concerns.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
e. A behavioral health professional has been fully integrated into patient care in our practice.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
f. Protocols and work flows have been implemented for warm-handoffs and standardized follow up with our behavioral health provider.	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5
g. Patient medical records are accessible to both behavioral and physical	<input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4

health providers.	⑤
h. Personalized patient care plans are shared between behavioral health and primary care clinicians.	① ② ③ ④ ⑤

Practice name:

Date Monitor completed: _____

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SIM Contractor Progress Report: Rocky Mountain Health Plans

Reporting Period: October 2013 - **FINAL**

Date Submitted: November 5, 2013

Contractor Name: Rocky Mountain Health Plans (RMHP)

Grant Amount: \$400,000

Contractor Role: Develop curricula, communication channels and new community structure for the integration of behavioral health and primary care workforce supports

Guiding Questions to incorporate into Deliverables:

[Note: Not all guiding questions apply to each contractor. These are meant to guide as applicable]

- What is the current “as is” state of health in Colorado from this sector/stakeholder perspective?
- What is the preferred “to be” state from that perspective?
- What is the “innovation opportunity” (i.e., the gap between “as is” and “to be”) for this sector/stakeholder?
- What are the key public health interventions needed to fill that gap?
- What data and outcomes measures should we use to measure progress?
- If the model Colorado plans to test is paying for integrated physical/behavioral health, what role can (sector/stakeholder group) play in facilitating that integration or measuring its impact?

Updates on Project Deliverables

Deliverable 1 - Monthly Report deliverable: detail monthly activities and project status.

Innovation Opportunity:

RMHP, partnering primary care physicians, community mental health centers and Quality Health Network (hereinafter "the Partners") are working to create a framework for the training,

deployment and integration of a new workforce to accelerate the development of the advanced primary care and integrated behavioral health model.

Building upon a series of interdependent investments in technology, data sharing, practice transformation and collaborative learning, the Partners are working methodically to create new competencies in data use, measurement and whole-patient support at the point of care. This work entails the integration of behavioral health and other expertise on proactive primary care teams, and a fundamental shift away from “encounter-only” processes in clinical operations. Additionally, given the fact that behavioral and social determinants have a far greater impact upon patient outcomes and future costs than clinical processes, the Partners recognize the need to extend the integrated care model well beyond the walls of physician group practices. Workforce deployments alone are not necessarily innovative, but the integration of practice and community-based resources in a manner that incorporates community governance; data-driven prioritization; shared documentation; interventions that address physical, behavioral and social determinants; and a sustainable payment model is new territory. The Partners’ deliverables and shared community experience in each of these aspects of workforce integration will be pertinent to transformation efforts in numerous other communities.

The Partners’ SIM Pre-Testing engagement is therefore designed to accomplish the objectives described below. Key drivers for success (and replication in other communities) are specified for each objective.

Objective 1: Create a systematic, community-governed process for the recruitment, training, oversight and integration of Community Health Workers, who will be responsible for extending comprehensive primary care interventions and addressing social and behavioral health determinants in homes, community, peer group and other non-clinical settings.

Key Drivers for this Objective:

- **Learning** - Active, collaborative learning with community leaders in other SIM states
- **Governance** - Specifying community structures for executive oversight and program steering

- **Targeting** - Setting a specific focus area or performance improvement target to generate engagement
- **Data** - Developing data assets and building aligned reporting tools for prioritization and operations

Actions Since the Last Report:

Work accelerated toward completion of this Objective during the month of October. Specifically, HET Steering Committee met three on two (2) additional occasions, executed practice MOU agreements and finalized the training curriculum, the regional implementation plan and timeline. Key objectives are as follows:

As noted in the previous progress report, the HET Steering Committee is comprised of executive-level representation from the **Mesa County Physicians IPA**, three selected advanced primary care practices (**Foresight Family Physicians, Primary Care Partners, and Peach Valley Family Medicine**), the **Mind Springs** and **Midwestern Colorado Mental Health Centers**, and **Rocky Mountain Health Plans'** medical management, practice transformation and community integration teams.

The HET Steering Committee agreed that CHW will meet directly with care management leads within each of the advanced primary care practices to complete the orientation and integration processes, with oversight from HET Steering. Care managers from each physician pod or grouping within practices will finalize the ranked list of outliers provided by the RCCO, removing individuals no longer served by the practice from the target cohort, and adding others that will benefit from support but are not (yet) reflected in administrative data provided by the RCCO. A single CHW will be appointed to lead for each practice, but others will backfill with clients as necessary on a day-to-day basis due to time out of office or other logistical issues. The Steering Committee also agreed that a warm hand-off, coordinated by the practice care managers, in the practice setting, will be utilized to introduce the CHWs to patients and establish a relationship. HET follow-up processes will be established when patients decline to participate, particularly when mental health issues and/or substance abuse issues are key drivers of patient experience and utilization patterns.

The Steering Committee committed to establishing routine oversight meetings, which include IPA, CMHC, RCCO and practice leadership, to ensure that performance targets are actively monitored and that systemic issues are identified early in the design cycle as model is scaled. The Steering Committee also set a 1Q14 implementation date for model expansion in Montrose and Garfield counties. The Steering Committee will be expanded commensurately at that time to include an advanced FQHC, as well as several other practices participating in CPCi and regional-level transformation programs sponsored by the RCCO.

As documented in agreed operating principles, support from the RCCO's practice facilitation team will be made available as necessary to support the behavioral health and CHW integration process.

Objective 2 - Align plans for development of the Community Health Worker resource with the development of in-practice resources for patient activation, shared decision-making and self-management processes. Develop a multi-party process in which primary care practices drive and are accountable for patient outcomes, but are supported more effectively in addressing health determinants that are well-outside the scope of their clinical operations.

Key Drivers for this Objective:

- **Training** – Curricula development, role definitions and a recruiting plan
- **Timing** - Setting a specific time horizon for milestone development and measurement
- **Integration** - Linking community workforce development with in-practice resource development –
- **Alignment** – Build upon existing practice transformation resources and measurement initiatives -
- **Vision** – Articulate and work within a vision regarding how current focus areas and performance targets will evolve, and how sophistication will increase following completion of initial milestones

Actions Since The Last Report

HET Steering Committee adopted [Final](#) workforce training curricula, building upon criteria gathered from partnering sites (Central Oregon CCO) and other state CHW certification programs (Ohio). CMHCs will utilize these criteria to deploy staff within the agreed implementation timeframes in Mesa County, and subsequently in Montrose and Garfield counties.

The HET Steering Committee also agreed to utilize “Minimum Data Set” elements and measures established within the integrated behavioral health payment reform initiative (“SHAPE”) for performance assessment activities, along with routine measures of utilization (impact upon chronic emergency department utilization). Adoption of these measures will minimize unnecessary duplication for the practices and the HET Steering Committee, and facilitate learning and diffusion within broader channels. SHAPE was launched and is sponsored in Colorado by Rocky Mountain Health Plans (Payer), the Collaborative Family Healthcare Association (CFHA – Convener), and the University of Colorado Department of Family Medicine (UCD-DFM – Evaluator, with funding from the Colorado Health Foundation). SHAPE is currently being replicated in Oregon within two CCOs (Central Oregon and Yamhill County).

Data extraction processes from participating integrated practices have been developed, and will commence under oversight from Quality Health Network (QHN) in 4Q13. QHN will aggregate, normalize and de-identify individual patient level data within the Minimum Data Set for evaluation by the UCD-DFM.

HET Steering has agreed that the performance measurement period for attributed patients within the HET cohorts will be 12 months, with a full review, assessment and adjustment process prior to Year 2.

The HET agreed that specific assignment of practice-based care management leads would be established for each HET Cohort, by physician pod.

Objective 3 - Align technology and payment to support the model, so that patient status is current and viewable (at appropriate levels of access, driven by rights and roles architecture) to all participants in the Health Engagement Teams. Expand global payment model for primary care practices to finance non-encounter, asynchronous, proactive care management processes. Develop regular, community reporting and executive committee oversight of progress, with specific milestones and measures of performance. Document and disseminate the model and lessons learned within the statewide Colorado innovation structure.

Key Drivers for this Objective:

- **Tools** - Defining objectives and specific use cases to drive technology deployment
- **Payment** – Develop a clear line of sight and an analytical connection in the governance structure between total cost performance, reformed payment methods and the sustainment of value-creating workers, tools and processes
- **Structure** – Define delegation and consent processes clearly to maximize the flow of information and address barriers to coordination (actual and perceived)
- **Monitoring** - Assess performance, report results through executive oversight and within the community learning collaborative
- **Documentation** – Document outcomes, successes, failures and lessons learning for public review
- **Communication** - Active dissemination and communication processes

Actions Since The Last Report

As noted in the previous report, RMHP conducted the Region-Wide Executive Committee kick off meeting on September 30th. The Executive Committee will have oversight of all payment reform and community interventions, including the HET. The Executive Committee includes the following members:

First	Last	Title	Organization
John W.	Barbie	Senior Advisor on Issues of Civil Society & Accessibility	Consumer Representative
Ross	Brooks	Executive Director	Mountain Family Health Centers
Steve	ErkenBrack	President & CEO	Rocky Mountain Health Plans
John	Gordon	Executive Director	Midwest Colorado Center for Mental Health
Jeff	Kuhr	Executive Director	Mesa County Health Department
Mike	McBride	President & CEO	St. Mary's Hospital & Regional Medical Center
Ben	Miller	Associate Professor	University of Colorado, Department of Family Medicine
Sharon	Raggio	CEO	Mindspring Health
Greg	Reicks	President	Mesa County Physicians Independent Practice Association
Pat	Riddell	Executive Director	Western Colorado Independent Physicians Association
Mike	Stahl	CEO	Hilltop Community Services
Dick	Thompson	CEO	Quality Health Network
Martie	Wisdom-Edwards	Executive Director	Valley Health Alliance Employer Initiative

The Steering Committee will report the final HET framework to the Executive Committee at the next meeting on November 22nd. The focus of the discussion will be the RCCO financing arrangements (via agreements with each of the participating practices and the CMHCs) to finance the HET implementation. Longer-term sustainment will be achieved within the Colorado Accountable Care Collaborative payment reform initiative, implemented within the 7-county region pursuant to Colorado House Bill 12-1281. Gains for actual experience that is favorable to projected cost trends will be shared as follows:

1. Primary Care Practices 30%
2. CMHCs 30%
3. State of Colorado 30%
4. RCCO 10%

Additionally, the HET agreed to commence a series of level-setting discussions to focus upon limitations regarding the sharing of information about substance abuse treatment and mental health conditions. The actual scope of regulatory constraints is substantially less than what is commonly perceived in community discussions regarding care coordination. Further, the detail necessary to support effective, multi-party coordination is far less than that which is detailed in the clinical record. HET Steering will work to establish understanding and agreement among HET members to clarify how to achieve effective communication regarding the status of patients within the HET cohort with practice care managers. A contact sheet has been drafted by the Committee to focus this level-setting process. The CMHCs have established a separate legal entity in order to clarify their role within the HET and to distinguish the interventions they will

support from the treatment services they provide in their capacity as an established community provider of episodic and acute mental health and substance abuse services.

Deliverable 2- Final Report deliverable: produce a final report that includes a summary of activities attempted and completed, the Integration Plan, and replication of guidelines for use of the developed plan (curricula, communication channels, and community structures) in other regions.

Current Status: Final Deliverable is Complete. See attached summary.

SIM Contractor Progress Report

Executive Summary

RMHP, partnering primary care physicians, community mental health centers and Quality Health Network (hereinafter "the Partners") are working to create a framework for the training, deployment and integration of a new workforce to accelerate the development of the advanced primary care and integrated behavioral health model.

The Partners' SIM Pre-Testing engagement is designed to accomplish the objectives described below.

- **Objective 1:** Create a systematic, community-governed process for the recruitment, training, oversight and integration of Community Health Workers, who will be responsible for extending comprehensive primary care interventions and addressing social and behavioral health determinants in homes, community, peer group and other non-clinical settings.
- **Objective 2 -** Align plans for development of the Community Health Worker resource with the development of in-practice resources for patient activation, shared decision-making and self-management processes. Develop a multi-party process in which primary care practices drive and are accountable for patient outcomes, but are supported more effectively in addressing health determinants that are well-outside the scope of their clinical operations.
- **Objective 3 -** Align technology and payment to support the model, so that patient status is current and viewable (at appropriate levels of access, driven by rights and roles architecture)

to all participants in the Health Engagement Teams. Expand global payment model for primary care practices to finance non-encounter, asynchronous, proactive care management processes. Develop regular, community reporting and executive committee oversight of progress, with specific milestones and measures of performance. Document and disseminate the model and lessons learned within the statewide Colorado innovation structure.

Participants and Governance

The Partners have agreed to pursue their three key objectives within a comprehensive, multi-lateral governance and performance oversight process. This framework operates at three (3) levels:

- **Health Engagement Teams (HET)** - A multi-disciplinary team led by advanced primary care practices, which includes practice-based care managers, behavioral health providers, community health workers, human services providers, hospital social workers, and RCCO medical management and analytics staff.
- **HET Steering Team** - This committee is comprised of executive-level representation from the **Mesa County Physicians IPA**, three selected advanced primary care practices (**Foresight Family Physicians, Primary Care Partners, and Peach Valley Family Medicine**), the **Mind Springs** and **Midwestern Colorado Mental Health Centers**, and **Rocky Mountain Health Plans'** medical management, practice transformation and community integration teams.
- **Regional Executive Committee** - The regional Executive Committee is comprised of chief executive representation from primary care, physician networks, hospital providers, employers, community mental health, local public health agencies, technology and payer representatives. The Executive Committee, shown below, allocates resources and creates accountability within all community integration and payment reform efforts:

First	Last	Title	Organization
John W.	Barbie	Senior Advisor on Issues of Civil Society & Accessibility	Consumer Representative
Ross	Brooks	Executive Director	Mountain Family Health Centers
Steve	ErkenBrack	President & CEO	Rocky Mountain Health Plans
John	Gordon	Executive Director	Midwest Colorado Center for Mental Health
Jeff	Kuhr	Executive Director	Mesa County Health Department
Mike	McBride	President & CEO	St. Mary's Hospital & Regional Medical Center
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Dick	Thompson	CEO	Quality Health Network
Martie	Wisdom-Edwards	Executive Director	Valley Health Alliance Employer Initiative

Goals and Roles

The HET Steering Committee established specific, agreed goals and roles for participants within the HET framework. Specifically:

- To extend new, primary care-based care management and internal behavioral health resources beyond the walls of your practice;
- To more efficiently address complex determinants of patient health that are attributable to behavior and social circumstances that are outside the scope of primary care and clinical operations, particularly within the low-income population;
- To expedite access to mental health and substance abuse treatment services when necessary, with a clear line of communication regarding patient status, follow-up and ongoing care management requirements;
- To develop and direct the expansion of community and peer-based interventions that are crucial to the achievement of medical neighborhood objectives, patient self-management and cost targets.

Agreed Roles

- **RCCO (RMHP)** will provide the funding, data, contractual accountability and measurement resources required to implement and sustain the program. Additional practice facilitation and care management resources will be provided as requested by the practices, as well.
- **Mind Springs Health** and **Midwestern Center for Mental Health (CMHCs)** will employ, train and supervise **Community Health Workers** who will participate within the HET structure, and ‘boots on the ground’ support for with behavior change, substance abuse and social services coordination – including transportation, accompanied practice encounters and peer-based interventions as necessary.
- **Mesa County Physicians’ IPA** will provide program steering, gap assessment, role definitions, interventions design, a practice feedback and dissemination channel, evaluation structure for the program, under the auspices of the Emergency Department Task Force;
- **Advanced Primary Care Practices** – Will appoint the care managers who will provide oversight of HET activities, coordinate communications, review applicable data, form and maintain targeted cohorts of patients for HET support.

Collaboration and Measurement

The HET model, as well as the training curricula and practice protocols for care management, have been developed in partnership with community organizations in other SIM states (e.g. the Central Oregon CCO). Additionally, workforce training criteria have been developed utilizing formal state certification created in other states (e.g., Ohio).

The HET Steering Committee also agreed to utilize “Minimum Data Set” elements and measures established within the integrated behavioral health payment reform initiative (“SHAPE”) for performance assessment activities, along with routine measures of utilization (impact upon chronic emergency department utilization). Adoption of these measures will minimize unnecessary duplication for the practices and the HET Steering Committee, and facilitate learning and diffusion within broader channels. SHAPE was launched and is sponsored in Colorado by Rocky Mountain Health Plans (Payer), the Collaborative Family Healthcare

Association (CFHA – Convener), and the University of Colorado Department of Family Medicine (UCD-DFM – Evaluator, with funding from the Colorado Health Foundation). SHAPE is currently being replicated in Oregon within two CCOs (Central Oregon and Yamhill County).

Timeframe and Sustainability

The HET process will commence in Mesa County in January 2014, via established practice agreements with the RCCO, and will be expanded to Montrose and Garfield counties by the end of 1Q14. Measurements will be compiled over the course of a 12 month evaluation period, with regular review by the HET Steering and Regional Executive Committees.

Longer-term sustainment will be achieved within the Colorado Accountable Care Collaborative payment reform initiative, implemented within the 7-county region pursuant to Colorado House Bill 12-1281.

SIM Contractor Final Report: Community Reach Center

Reporting Period: September 2013

Date Submitted: October 4, 2013

Contractor Name: Community Reach Center

Grant Amount: \$76,000

Contractor Role: To assess the needs for ongoing integrated health care efforts

Guiding Questions to incorporate into Deliverables:

[Note: Not all guiding questions apply to each contractor. These are meant to guide as applicable]

- What is the current “as is” state of health in Colorado from this sector/stakeholder perspective?
- What is the preferred “to be” state from that perspective?
- What is the “innovation opportunity” (i.e., the gap between “as is” and “to be”) for this sector/stakeholder?
- What are the key public health interventions needed to fill that gap?
- What data and outcomes measures should we use to measure progress?
- If the model Colorado plans to test is paying for integrated physical/behavioral health, what role can (sector/stakeholder group) play in facilitating that integration or measuring its impact?

Updates on Project Deliverables

Deliverable 1: (Please state the specific deliverable that you are responsible for completing for the SIM grant) 4.1.1 Work with three (3) full time School Based Therapists that meet the

following qualifications (see Deliverables 2, 3, 4 which are items: 4.1.2/ 4.1.2.1/ 4.1.2.2/ 4.1.2.3)

1. Adams 5 Star Schools with 2 Community Reach Center School Based Therapists / 1 School Based Therapist at Thornton High School and 1 School Based Therapist at Northglenn High School to assess the substance abuse treatment needs as well as the integrated health care opportunities.
2. Mapleton School District staffed with 1 Community Reach Center School Based Therapist at Skyview Campus. Community Reach Center is a participant in the planning stages associated with an integrated healthcare opportunity Clinica.

Current Status: (Please provide detailed information about your current progress on this deliverable)

All 3 School Based Therapists are hired and aside from their non-SIM funded service provisions, have been collaborating with their respective school staff, administration, families, and students to assess needs for integrated health care. Clinical Director and Program Manager for School Based Therapists assisting with the training and introductions to community partners associated with deliverables of this grant.

Explanation of Variance (If applicable): (If you are behind schedule on this deliverable, please explain why and how you plan to meet your next deadline)

Deliverable 2: 4.1.2 Collect Data and establish a baseline regarding current levels of integration of health care in school based centers.

Current Status:

Community Reach Center meeting with Adams 5 Star School District Staff and reviewed data points and determined placement for School Based Therapists and continue to discuss efforts around vision for integrated care in the high schools.

Community Reach Center collaborating with the Clinica Family Health Services/ Mapleton Public Schools Planning Committee

Example of Baseline Data being discussed:

- Student population for Mapleton
 - 7,000 students enrolled in ‘brick and mortar’ schools
 - 1,000 students across the state attending online school
- Mapleton’s poverty rate has doubled in the last 10 years, from 35% - 78%
- Impacts of poverty on Mapleton students
 - Concerned students are missing a lot of school because they do not get the care they need and/or don’t have access to the care they need.

Explanation of Variance (If applicable):

Deliverable 3: 4.1.2.2 Conduct a needs assessment to support ongoing integrated health care efforts in school based settings

Current Status:

The School Based Therapy Program is by its very nature a collaborative effort that brings together Adams County Schools and Community Reach Center and reflects the efforts of the Adams County Youth Initiative (ACYI). ACYI is a 501(c)(3) nonprofit organization made up of leaders in education, nonprofit, human services, law enforcement and other community organizations who work to ensure cradle to career success for Adams County children and young people by focusing on: 1) Decreasing Delinquency 2)Decreasing Substance Use 3) Increasing High School Graduation Rates.

Long Term Goal:	<i>Children have access to preventative comprehensive health care (medical, oral, developmental and mental health)</i>
2013 Goal:	<i>Increased number of families follow through with health referrals</i>
2013 Baseline:	<i>Identify number of parents who do not follow through with referrals for developmental evaluations or other health services (% of Referrals from</i>

	<i>Health Clinics that go to Evaluation: CO=69%, Adams CO=52%; declining trend over 2 yrs)</i>
Data Sources:	<i>Early Intervention data; CRC data, Health clinic data</i>

As well as:

Long Term Goal:	<i>Decrease all drug use</i>
2013 Goal:	<i>Decrease the number of students using prescription drugs by 5% for 2013 – 2014</i>
2013 Baseline:	<i>Students who reported using marijuana in the past 30 days were nearly 5Xs more likely to also report using prescription drugs, compared to students who did not use marijuana.</i>
Data Sources:	<i>Adams County Student Survey, 2011-2012</i>

Using resources such as:

<http://dola.colorado.gov/gis-cms/content/custom-poverty-map-acs-2007-2011>

ACYI and our Cradle to Career action teams are mapping out resources and need to identify next steps.

Needs assessment from ACYI Adams County Student Survey and Needs Assessment from Clinica have been tools to determine baseline and next steps.

Explanation of Variance (If applicable):

Deliverable 4: 4.1.2.3 Collaborate with other health care providers in or around Adams County and other School Based Therapists to assess the needs for ongoing integrated health care efforts in school based setting.

Current Status:

Community Reach Center collaborating with the Clinica Family Health Services/ Mapleton Public Schools Planning Committee:

9/4/13 Mapleton/ Clinica monthly steering meeting:

Update on Resolution/MOU

Update on Medicaid enrollment process at Mapleton Bridge to Care: Reducing risk while creating access to medical care

- What are our opportunities?
 - Patient recruitment
- What information do we need?
 - Of Clinica patients/students, how many have family members who are also Clinica patients or want to become patients?
 - Is this group of people interested in moving to the future Skyview Clinic?
- Opening Skyview Clinic
 - What is the sweet spot that determines we need a clinic at Skyview?

How much advance notice do we need before opening a clinic?

SIM Contractor Final Report: Colorado Access

Reporting Period: September, 2013

Date Submitted: October 7, 2013

Contractor Name: Colorado Access

Grant Amount: \$60,000

Contractor Role: RCCO Regions 2, 3 and 5

Abstract (Overview of accomplishments, outcomes, substantive findings, which you will describe in greater detail through the questions below)

- Accomplishments
- Outcomes
- Substantive findings
- Suggestions/Recommendations
- Additional Information

1. What is the “as is” state of health in Colorado from this sector/stakeholder perspective?

1. Integration of behavioral and physical health services is essential for improving overall health outcomes, however there continue to be regulatory constraints, specifically HIPAA and 42 CFR, that pose barriers to full integration of care.

2. Both primary care and behavioral health providers are eager to pursue integrated care opportunities and are developing creative and innovative programs despite continued regulatory challenges.

3. Claims and utilization data will be powerful tools to understand the full health care experience of Medicaid recipients. Currently, this information is available to the RCCOs and PCMPs, however, does not include behavioral health claims and encounter data. Consequently, our current data represents only the physical health information for Medicaid members and is most likely underestimating the clinical risk scores and service utilization/costs for this population.

2. What is the preferred “to be” state from that perspective?

1. The ability to freely exchange physical and behavioral health claims and utilization data so that all providers have a comprehensive picture of a member's total health care experience. Care management and treatment interventions will be better designed and implemented with access to a comprehensive service data set.

2. Primary Care Providers will have simple, effective means of accessing behavioral health services for the ACC patients. Such services may be rendered along a continuum of knowing how to refer their patient to specialty behavioral health care to a fully integrated model in which the behavioral health provider is working within the primary care setting. At any point in this continuum, there is reliable and timely bi-directional exchange of clinical information and ongoing coordination of care.

3. What is the “innovation opportunity” (i.e., the gap between “as is” and “to be”) for this sector/stakeholder

1. Clearer direction from the Department regarding the expectations of bi-directional information exchange and shared care coordination between behavioral and physical health providers. In the absence of a statewide policy that eases provider anxiety about HIPAA and 42 CFR compliance, RCCOs and BHOs are forced to develop unique data sharing agreements according to their own organizational legal guidance, resulting in a variety of processes and arrangements across the state. The “innovation opportunity” is to develop a broad information exchange policy that adequately addresses current regulatory obstacles.

2. The absence of behavioral health claims and encounter data in the SDAC dashboard compromises the quality and value of this information. As noted above, clinical risk scores are likely to be very understated, thus limiting a primary care provider's ability to provide care from a "whole person" perspective. While we understand that there are current technical and data format issues that prevent behavioral health data from being incorporated in the SDAC dashboard, the innovation opportunity is to develop solutions to those issues as soon as possible so that we all have a more complete picture of ALL of our members health care needs.

3. As noted in earlier reports, Colorado Access supports the Department's consideration of designating high functioning, well integrated community mental health centers as PCMPs. We applaud the Department's interest in soliciting broad stakeholder input regarding the expansion of PCMP designation to other specialty providers, including mental health centers. An innovation opportunity would be to pilot such a program with a handful of mental health centers to test the assumption that these providers can be effective medical homes for a high need/high risk subset of the Medicaid population.

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

1. In the recent release of the draft RFP for the BHO re-bid, we were encouraged to see such compelling support for advancing the integration of behavioral and physical health care services. This has invigorated discussions between RCCOs and their regional behavioral health partners to develop communication and coordination strategies between providers. As such, one outcome measure would be to look at how many primary care practices have established referral and communication mechanisms in place for behavioral health treatment.

2. As noted above, we support the inclusion of mental health centers as PCMPs and believe that they could demonstrate that behavioral health care management interventions can positively impact the patient experience of care and reduce Medicaid health care costs. Colorado Access is currently engaged in a pilot project with four mental health centers in Regions 3 and 5 to test this theory.

5. If the model Colorado plans to test is paying for integrated physical/behavioral health, what role can (sector/stakeholder group) play in facilitating that integration or measuring its impact?

1. The RCCOs have already established sound working relationships with their regional behavioral health partners. Consequently, we can be a convener to pull behavioral and physical health providers together to explore and exchange best practices and integration strategies.

Deliverables

Deliverable 1: The role of and understanding of HIPAA and other policy issues in integration.

Status: No material changes to this deliverable since the August report. Colorado Access continues to provide our partner mental health centers with common member files that identify Medicaid members who are both enrolled in RCCO and are receiving behavioral health services. As noted above, we have launched a pilot program with four mental health centers in Regions 3 and 5 with a subset of these common members who have high ED utilization and/or high total claims cost over the past year. This study has been underway since early July in Denver, and will be fully underway in Region 3 in October. At the conclusion of these pilot programs, we will evaluate whether or not ongoing formal care management arrangements between the RCCO and mental health center make sense. We will continue to connect our primary care providers with an easy, streamlined mechanism for referral to behavioral health providers while ensuring timely exchange of clinical information and appropriate sharing of care management responsibilities. With guidance from our corporate legal counsel, we have successfully executed data sharing agreements that address shared concerns regarding HIPAA and Colorado confidentiality regulations.

Deliverable 2: What clinical data is available to the RCCO beyond SDAC reporting and should that data be integrated into the SDAC if feasible?

Status: No material updates to this deliverable since the August report, except as noted earlier in this report. Colorado Access fully supports the Department and the SDAC in finding a solution to the current data issues that prevent behavioral health claims and encounter data to be

incorporated into the SDAC dashboard. Until a broader systemic solution is implemented, we will continue to provide physical health claims data to our mental health center providers in accordance with a mutually agreed upon minimum necessary data set. We will continue to explore how this data is used by behavioral health care managers to address the interactive relationship between physical and behavioral health conditions and outcomes.

Deliverable 3: The RCCOs will report to the department the process for communicating and exchanging data and care management plans with the BHOs and state goals of planned integration.

Status: As noted above and in prior SIM grant progress reports, RCCO regions 2, 3 and 5 all have excellent working relationships with the BHOs and mental health centers that serve our respective regions. Monthly BHO/RCCO dyad meetings are held to discuss how the physical health data provided to the behavioral health providers is used in treatment. Specifically, exchange of this data has promoted outreach by the behavioral health provider to the members PCMP. Historically, the behavioral health provider has been dependent on member self report about where they receive their primary care services. Provision of the name and contact information for the PCMP has helped improve bidirectional communication and coordination of care. In addition, mental health centers continue to assist unattributed members in selecting their PCMP through the enrollment broker. These meetings have also proven to be an opportunity to identify high volume PCMPs who may need assistance in arranging for behavioral health referrals for their ACC enrolled patients. Over the course of this grant, we have convened meetings with at least 10 PCMP practices to identify effective referral and communication mechanisms. These connections have resulted in some of our PCMPs being willing to serve more members with significant behavioral health diagnoses as they are more confident that they can get timely access to behavioral health services.

Colorado Behavioral Health Care Council (CBHC), the trade organization that represents Colorado's community mental health system and SUD providers, has recently hired a staff member who will oversee the Colorado Psychiatric Assessment and Consultation for Kids (C-PACK) program. C-PACK will provide pediatric and family medicine providers with nearly real-time consultation with child psychiatrists. As we know, over half of all psychotropic

medications are prescribed by primary care providers. Readily available psychiatric consultation affords these primary care physicians with a “safety net” for when they are feeling beyond their medical expertise in prescribing psychotropic medications. Additionally, C-PACK will be sponsoring a three day intensive training for primary care physicians to build their expertise and confidence with prescribing psychotropic medications. This training is tentatively scheduled for January 2014.

Included as PDFs or Excel files in Appendix folder

Lexicon for Behavioral Health and Primary Care Integration (PDF)

SIM Contractor Final Report: Colorado Community Health Alliance (PDF)

SIM Contractor Final Report: Office of Behavioral Health (PDF)

SIM Contractor Final Report: Metro Denver Homeless Initiative (PDF)

SIM Contractor Final Report: Colorado Coalition for the Homeless (PDF)

SIM Contractor Final Report: Colorado Commission on Indian Affairs/Lt Governor's Office (PDF)

Financial Analysis: Milliman (Excel)
