Colorado SIM Operational Plan

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SIM

State Innovation Model

Colorado SIM Operational Plan

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Executive Summary

The Colorado SIM Operational Plan charts a path to achieving Colorado SIM's overarching goal: to improve the health of Coloradans by providing access to integrated physical and behavioral health care services in coordinated community systems, with value-based payment structures, for 80 percent of Colorado residents by 2019. To turn this vision into a reality, Colorado SIM will leverage a Model Test award from the Center for Medicare and Medicaid Innovation (CMMI) to implement and expand upon activities outlined in Colorado's State Health Innovation Plan (SHIP), created with support from a CMMI Model Design Award.

During this first year of the Test Award, Colorado has laid a strong foundation for the implementation of the SIM Model Test, rooted in collaboration and a shared vision for transformational change within the state. Since receiving the award in February 2015, Colorado has established the Colorado SIM Office, appointed an Advisory Board, convened Stakeholder Workgroups consisting of 134 thought leaders, garnered commitments from public and private payers, conducted a statewide outreach tour, and held more than 70 stakeholder meetings. The activities outlined in this Operational Plan directly reflect Colorado's commitment to engage with stakeholders from across the health care spectrum to develop and implement an action plan for integrating physical and behavioral health care, improve population health by leveraging public health and community resources, and shift from fee-for-service reimbursement structures to prospective value-based payment models that improve care quality and outcomes.

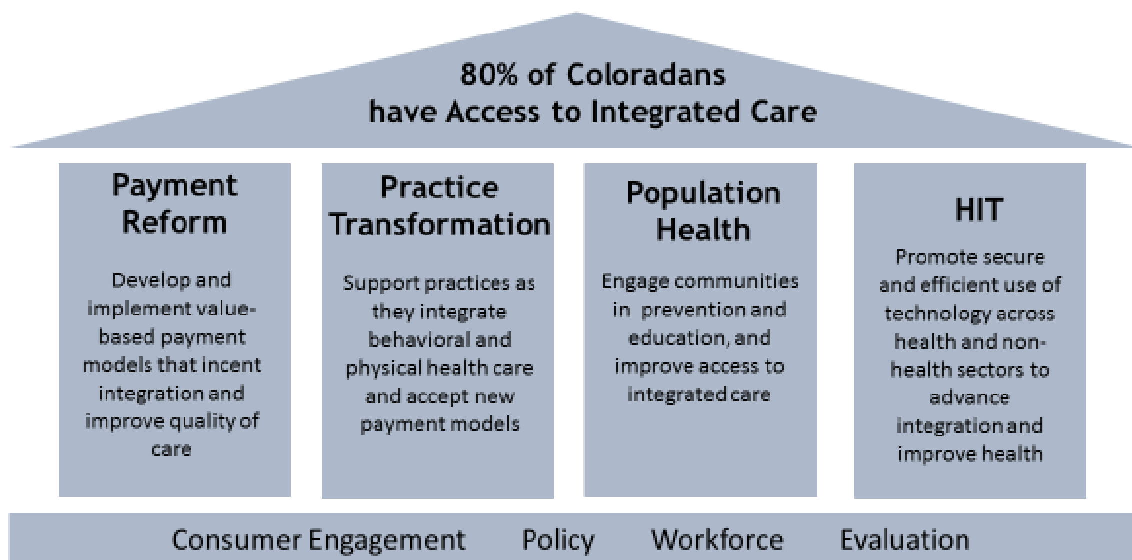
The SIM Operational Plan outlines Colorado's four-pillar approach to innovation: 1) providing access to integrated primary care and behavioral health services in coordinated community systems; 2) applying value-based payment structures; 3) expanding information technology efforts, including telehealth; and 4) finalizing a statewide plan to improve population health. The plan leverages practice transformation, payment reform, health information technology (HIT), and public health efforts to build upon the success of existing initiatives like the Comprehensive Primary Care Initiative (CPCI) and the Medicaid Accountable Care Collaborative (ACC). Furthermore, the plan details how Colorado SIM will engage consumers, develop workforce capacity, and utilize a range of policy and regulatory levers to address current systemic barriers and pave the way for future innovation and transformation. Finally, the document addresses how a dynamic evaluation plan, which aligns Clinical Quality Measures (CQMs) with population-based data and focuses on rapid-cycle feedback, will allow Colorado SIM to identify areas that need improvement in real time and build on strategies that show particular promise.

When fully implemented, the plan is projected to generate $126.6 million dollars in total cost of care savings by 2019, with annual savings of $85 million thereafter to help sustain Colorado's model. Furthermore, by expanding access to integrated care, the plan will improve the experience of care for the individual consumer as well as the health of the overall population. In short, the Test Award will accelerate Colorado's progress toward becoming the healthiest state in the nation. We are thankful for the opportunity and look forward to sharing the lessons we learn along the way.

Project Summary

Goal: The goal of Colorado SIM is to improve the health of Coloradans by providing access to integrated physical and behavioral health care services in coordinated community systems, with value-based payment structures, for 80 percent of Colorado residents by 2019.

Approach: Colorado SIM has synthesized payment reform, practice transformation, public health, and HIT strategies into a "four pillar" approach to achieving this goal.



Each pillar of this approach is supported by a foundation focused on ensuring that:

- Consumers are engaged in all elements of the SIM model;
- Policy and regulatory levers are utilized to address barriers and create opportunities to advance SIM's health care transformation efforts;

- Workforce capacity is developed to support these strategies; and
- Processes and outcomes are evaluated to measure progress and rapidly identify areas of high impact as well as those that need improvement.

Payment Reform

Colorado's payment reform strategy harnesses a uniquely successful multi-payer process that includes our state's major health plans, including: Aetna, Humana, Cigna, Kaiser Permanente, UnitedHealthcare, Anthem, Colorado Choice, Colorado Medicaid, Rocky Mountain Health Plans and Colorado Access, to date. This collaborative of payers was created under CPCI, but has grown to include SIM. This collaborative has rallied around the following as it relates to SIM:

- Participating payers will sign a voluntary Memorandum of Understanding (MOU) for SIM that outlines their shared commitment to a set of common CQMs, cost and utilization measures, data aggregation and value-based payment reforms in the context of a shared conceptual framework focusing on the Building Blocks for Whole Person Care; and
- Participating payers have expressed a commitment to encouraging formal Medicare participation in SIM within the larger context of Medicare's participation in CPCI.

Practice Transformation

Colorado SIM's Practice Transformation strategy, as detailed in this Operational Plan, focuses on:

- Providing practice transformation support to 400 primary care practices over the three-year implementation period of the award; and
- Supporting a Bi-Directional Integration Demonstration Pilot that will create integrated health homes in four Community Mental Health Centers (CMHCs).

Primary Care Practices

Colorado SIM will recruit 400 primary care practices to participate in practice transformation efforts over the course of the grant. Participating practices will be split into three cohorts. The first cohort, consisting of 100 practices, will launch in February 2016. Two additional cohorts of 150 practices each will be on-boarded in 2017 and 2018.

Practices selected for all SIM cohorts will commit to progressing toward implementation of 10 SIM Practice Transformation Milestones, based on the CMS' CPCI Milestones and Thomas Bodenheimer's "10 Building Blocks of High Performing Primary Care." Practices in all cohorts will receive the following support:

- Practice Facilitation;
- Clinical HIT Advisors (CHITAs);
- Bi-Annual Learning Collaboratives; and
- Access to capital.

Support will be delivered through a combination of 17 competitively selected Practice Transformation Organizations, the University of Colorado's Department of Family Medicine, the Colorado SIM Office, and other subject-matter experts.

Bi-Directional Integration

The Colorado SIM Practice Transformation strategy also includes a Bi-Directional Integration Demonstration Pilot that will create integrated health homes in four CMHCs. These health homes will provide comprehensive behavioral and physical health care to children, adolescents, and adults to stabilize and manage their illness and support their recovery. Because CMHCs serve as the primary locus of care for many Coloradans, particularly those managing a serious mental illness (SMI) or addiction, the CMHC-based integrated health home represents the best opportunity for the greatest cost reduction for individuals with the greatest needs and costs of care. The Bi-Directional Pilot will not only incorporate integrated/co-located primary care and ready access to more intensive behavioral health services, but will also include comprehensive care-planning and management; health care coordination; health

promotion/wellness activities; transition support across care settings; individual and family recovery support; and links to community services.

More details on the Colorado SIM Practice Transformation strategy are provided in the ***Health Care Delivery Transformation Plan*** section of the Operational Plan.

Population Health

Colorado SIM recognizes that the health of a state's population cannot be transformed within the walls of a clinic alone. As a result, the Colorado SIM population health strategy leverages the public health system to promote community outreach and education, reduce stigma, develop provider training, and advance locally-identified strategies for prevention of behavioral health disorders. Partnerships with the Colorado Department of Public Health and Environment (CDPHE) as well as the Office of Behavioral Health (OBH), housed within the Colorado Department of Human Services (CDHS), will be crucial to Colorado SIM's success.

Key activities related to population health include:

- Funding up to five Behavioral Health Regional Collaboratives (BHRCs), which are partnerships of three or more organizations working to increase access to behavioral health care and to improve behavioral health outcomes;
- Funding up to ten Local Public Health Agencies (LPHAs) to support activities that promote behavioral health and improve community-based awareness, and prevention and screening of behavioral health disorders;
- Development and dissemination of provider education on depression in men, pregnancy-related depression, obesity and depression, substance use disorders (SUDs), behavioral health interventions for senior citizens, trauma-related issues, and other relevant topics as needed;
- Identification of barriers to implementing Screening, Brief Intervention, and Referral to Treatment (SBIRT), and suggestions on how to address these barriers;
- Development of a voluntary certificate program, which will provide training around core competencies to behavioral health providers integrating into the primary care setting; and
- Deployment of 20 Regional Health Connectors (RHCs) who will connect practices to LPHAs, social service agencies, and other community partners to ensure that these partners are coordinated in their efforts to achieve Colorado SIM's goal.

Colorado SIM's strategies to leverage the public health system and local and community resources will ultimately align with and accelerate other statewide initiatives to improve population health, including Colorado's Ten Winnable Battles and the Governor's State of Health. Furthermore, Colorado SIM has aligned the initiative's CQMs dataset with population-level indicators so that changes in health outcomes can be tracked at both the state and county levels. The ***Plan for Improving Population Health*** section of the Operational Plan provides a detailed discussion of this alignment and SIM's overall population health efforts.

Health Information Technology

Colorado SIM is committed to aligning HIT efforts throughout the state and working with partners to build upon existing infrastructure in order to provide practices, providers, and other stakeholders with actionable data. As detailed in the ***HIT*** section of the Operational Plan, Colorado SIM's HIT strategy focuses on the following:

- Creating a Shared Practice Learning Integration Tool (SPLIT) to assess practice readiness for transformation;
- Establishing data acquisition and aggregation processes that include aggregation of clinical and behavioral health data at the patient level;
- Creating reporting tools that will provide practices and other relevant stakeholders with actionable data;
- Laying the foundation for integration of clinical and claims data; and
- Developing a statewide telehealth strategy that supports expansion of broadband access and establishes Telehealth Resource Centers to engage patients and providers.

In addition, Colorado's HIT plan includes the concept of SIM "All-Stars" – practices, organizations, and programs that achieve advanced levels of practice improvement, systems and data usage for measurement and improvement – that will be selected and highlighted by the SIM Office as models for other practices participating in SIM. SIM "All-Stars" will be able to broadly incorporate and demonstrate SIM concepts, and will play a key role in the development and dissemination of systems and processes that support the production and sharing of quality data.

Consumer Engagement

Colorado SIM will make every effort to ensure that consumer wants, needs, and preferences guide all of SIM's efforts. The ***Stakeholder Engagement*** section of the Operational Plan outlines actions the SIM Office will take to:

- Expand its Advisory Board to include greater consumer representation; and
- Work toward ensuring that consumer engagement priority areas, identified by the Consumer Engagement Workgroup, are incorporated into SIM activities.

Furthermore, SIM Practice Transformation milestones, discussed in the ***Health Care Delivery Transformation Plan*** section, include a strong focus on patient experience, and the Consumer Engagement Workgroup will provide guidance on how relevant milestones can be achieved.

Policy

Colorado SIM will utilize a variety of policy and regulatory levers to advance SIM goals and objectives across the four pillars of the model. The SIM Office and SIM Policy Workgroup will work to address identified barriers to integrated care delivery and alternative payment models, and will identify opportunities to advance policies and create a regulatory framework that support and foster future innovations and transformation of the state's health care system. Specific actions and strategies outlined in this Operational Plan include:

- Leveraging Medicaid and the state health employee plan as platforms to spur the adoption of integrated care delivery and value-based payment models within Colorado's marketplace;
- Coordinating and aligning regulatory oversight of the state's physical and behavioral health care systems;
- Exploring the use of state requirements for commercial insurance, including the rate review process, to reinforce and promote care delivery and payment reform;
- Advancing regulatory issues at the state and local level that improve population health; and
- Working with the Office of eHealth and other stakeholders to develop a statewide data governance structure.

Workforce Development

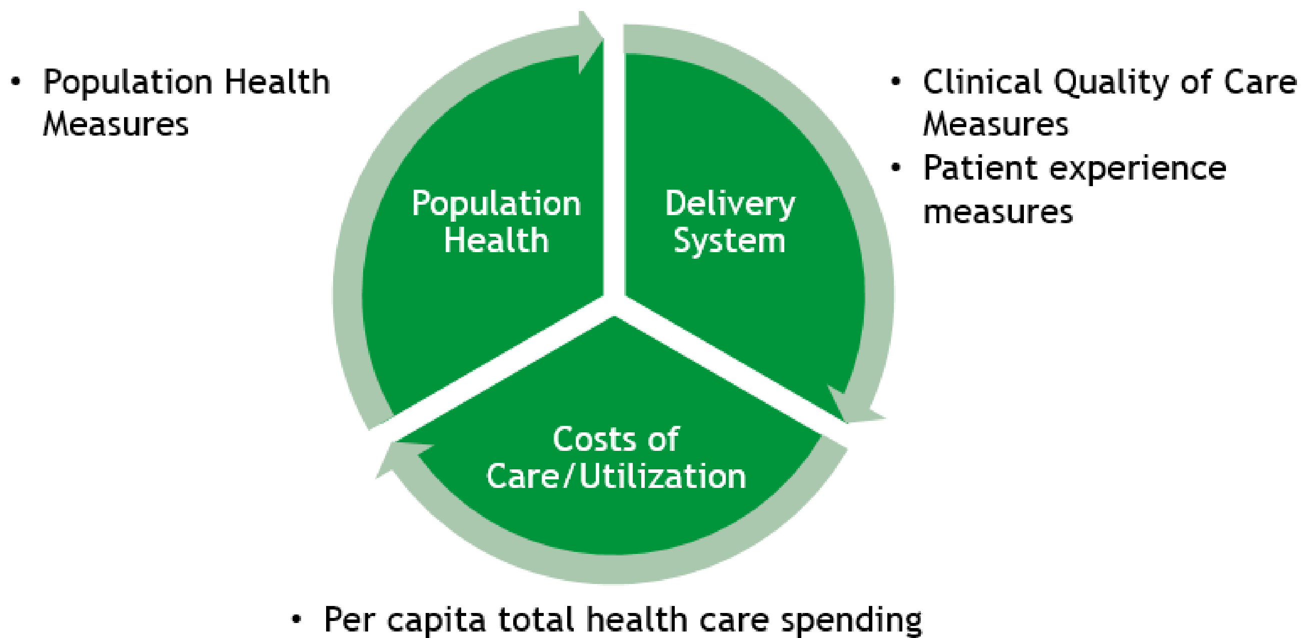
Colorado SIM is committed to developing the workforce capacity needed to support its four-pillared approach. The ***Workforce Development Monitoring*** section of the Operational Plan describes how the SIM Workforce Development Workgroup will:

- Support CDPHE's efforts to create a Provider Directory, designed to increase Colorado's base of Workforce Data;
- Develop a plan for change management roll-out that will engage providers, administrators, and educators before, during, and after the innovation;
- Partner with educational institutions to identify appropriate measures for defining workforce competencies and offer training that allows personnel to achieve high performance in an integrated care setting;
- Enumerate, align, and define competencies for Colorado's unlicensed workforce;
- Influence policies to address pipeline and workforce shortage issues; and
- Address other workforce-related issues as needed.

Evaluation

The Colorado SIM Office took recommendations from various stakeholder workgroups and subject-matter experts to select a set of measures that align at both the clinical and population levels to indicate the impact of SIM activities. SIM participating primary care clinics will be provided practice transformation and HIT support in reporting on a set of 18 CQMs. CDPHE will monitor 42 population health indicators that align with these clinical measures.

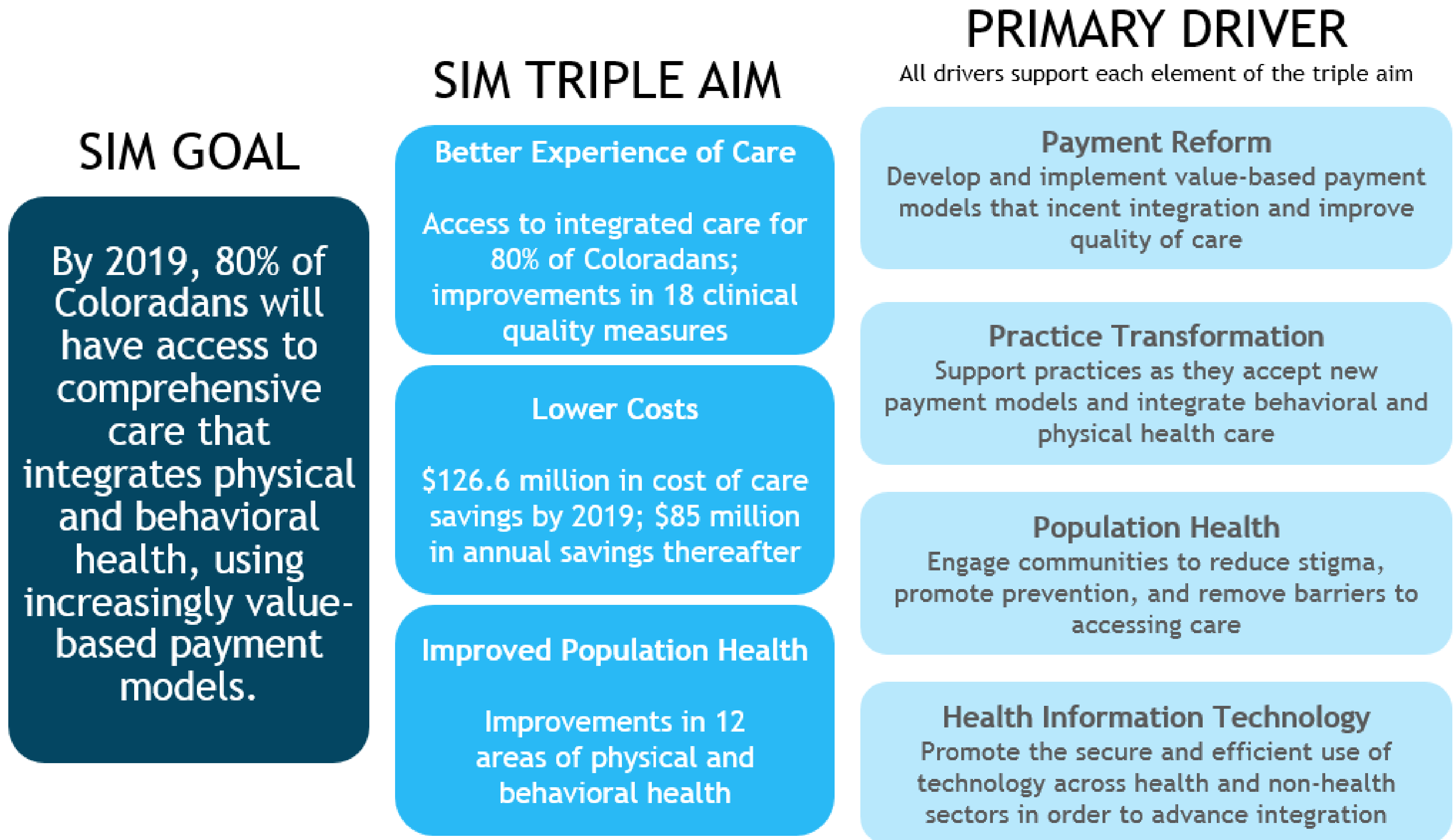
Furthermore, the Colorado SIM Office will work with an external evaluator to collect quantitative and qualitative data on a comprehensive range of SIM activities. Both processes and outcomes will be evaluated and reported on a quarterly basis so that best practices and areas requiring course corrections can be rapidly identified. Collectively, the SIM evaluation process will track progress toward achieving the triple aim of improving population health, lowering costs, and improving patient experience.

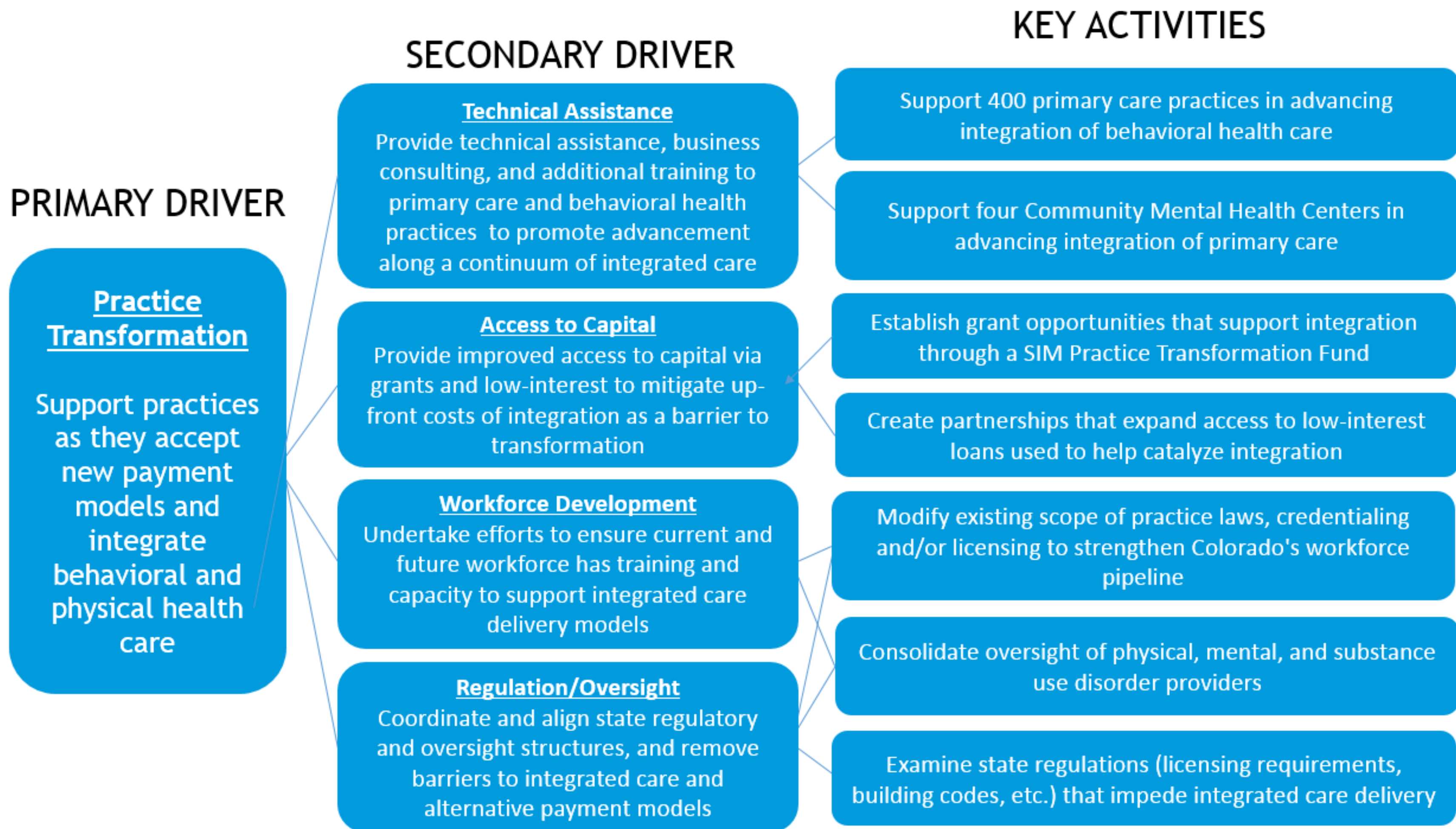


The ***Quality Measure Alignment, Program Monitoring and Reporting,*** and ***Data Collection, Evaluation, and Sharing*** sections contain information about specific metrics.

In addition to outlining key activities for each of the strategies listed above, the SIM Operational Plan addresses how stakeholders will be engaged in all elements of the SIM approach, as well as details on how key SIM activities will align with other initiatives across the state and accelerate their collective progress. Colorado SIM is confident that this comprehensive approach will create an innovative and sustainable framework for transformational change, during the terms of the grant and beyond. Due to the dynamic nature of the initiative, the SIM Office will update the Operational Plan at least annually, to maintain the most up-to-date information.

Driver Diagram




PRIMARY DRIVER
Practice Transformation
Support practices as they accept new payment models and integrate behavioral and physical health care
SECONDARY DRIVER
Technical Assistance
Provide technical assistance, business consulting, and additional training to primary care and behavioral health practices to promote advancement along a continuum of integrated care
Access to Capital
Provide improved access to capital via grants and low-interest to mitigate up-front costs of integration as a barrier to transformation
Workforce Development
Undertake efforts to ensure current and future workforce has training and capacity to support integrated care delivery models
Regulation/Oversight
Coordinate and align state regulatory and oversight structures, and remove barriers to integrated care and alternative payment models
KEY ACTIVITIES
Support 400 primary care practices in advancing integration of behavioral health care
Support four Community Mental Health Centers in advancing integration of primary care
Establish grant opportunities that support integration through a SIM Practice Transformation Fund
Create partnerships that expand access to low-interest loans used to help catalyze integration
Modify existing scope of practice laws, credentialing and/or licensing to strengthen Colorado's workforce pipeline
Consolidate oversight of physical, mental, and substance use disorder providers
Examine state regulations (licensing requirements, building codes, etc.) that impede integrated care delivery

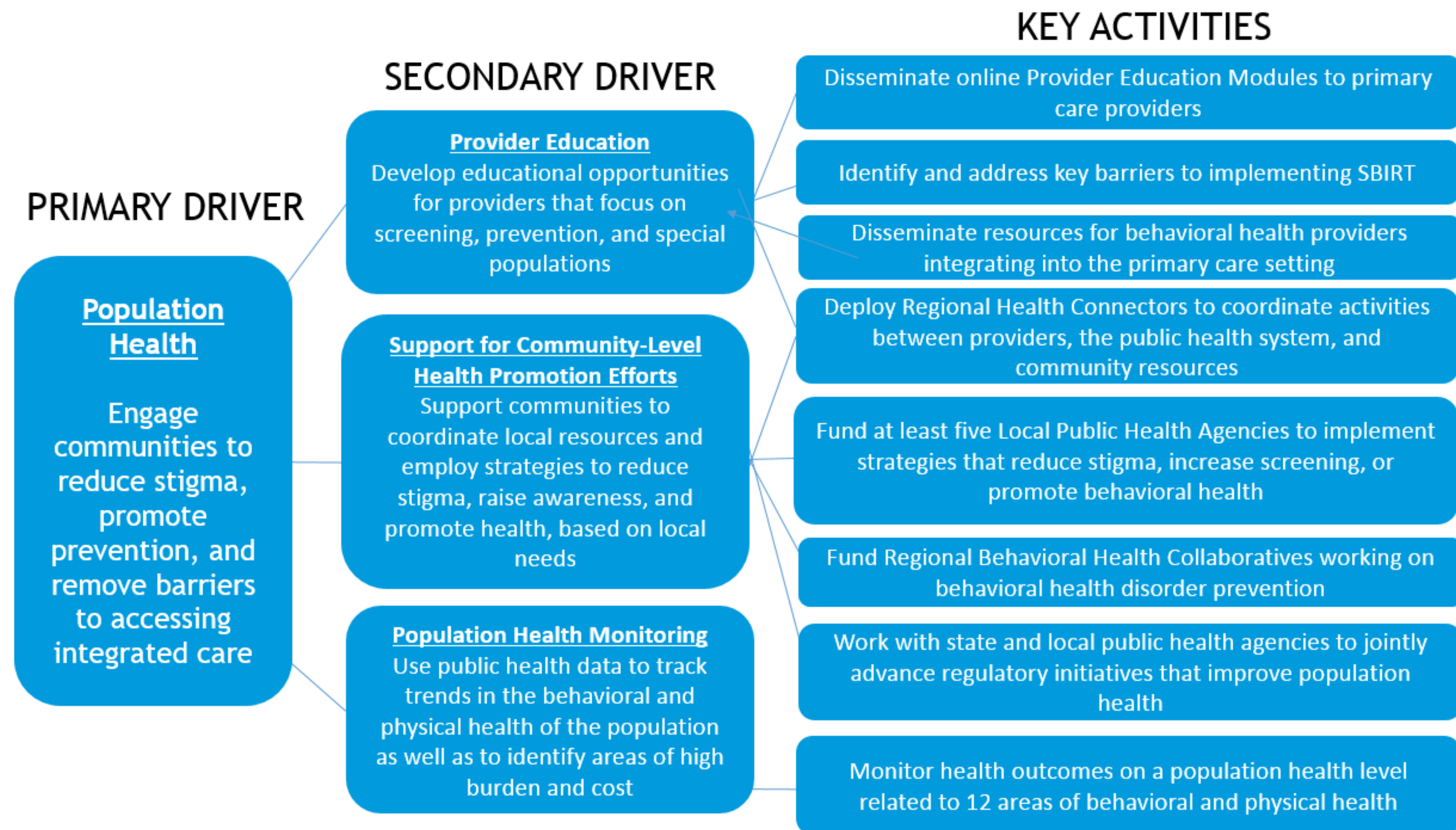
Primary Driver: Practice Transformation

TECHNICAL ASSISTANCE Key Metrics: # of practices participating in technical assistance activities.	**Support 400 primary care practices in advancing integration of behavioral health care**
	Select an initial cohort of 100 SIM-participating primary care practices to launch in 2016, with additional cohorts of 150 practices each to begin participation in 2017 and 2018.
	Train Practice Transformation Organizations to provide practice facilitation, Clinical Health Information Technology Advisors, and other technical support to SIM-participating primary care practices.
	Hold twice-yearly Collaborative Learning Sessions for participating practices.
	Develop an implementation guide and toolkits that assist practices in advancing toward achieving 10 milestones related to integration.
	Develop eight online training modules to support SIM-participating practices in achieving greater integration.
	Support four Community Mental Health Centers in advancing integration of primary care
	Four sites to complete "ramp-up" stage through January 2016, including hiring new personnel, infrastructure modifications, creation of new work flows, and establishment of reporting mechanisms.
	Sites enroll patients into integrated care model.
	Sites to propose sustainable alternative payment models.
	Colorado Behavioral Health Council to conduct in-person site visits and hold teleconference convenings between sites.

ACCESS TO CAPITAL Key Metrics: # of Practices Receiving Grants; # of Practices Receiving Low-interest Loans	**Establish SIM Practice Transformation Fund for primary care practices**
	Secure additional funding through private foundations and a possible federal match to augment the existing $3.25 million of SIM funds to create the SIM Practice Transformation Fund.
	Create guidelines that determine what specific purposes Practice Transformation Funds can be used for to support practices.
	Hold competitive RFA process for participating primary care practices to apply for funds to advance integration.
	Create partnerships that expand access to low-interest loans
	Confirm partnership with Vital Health Care Capital and set guidelines that govern loans to practices.
	Extend opportunity to apply for low-interest loans to SIM participating practices.

WORKFORCE DEVELOPMENT	Modify scope of practice laws, credentialing and/or licensing to strengthen Colorado's workforce pipeline
	Utilize the new CDPHE Provider Directory to identify key workforce pipeline issues.
	Participate in the Colorado Workforce Development Council's Healthcare Sector Partnership monthly check-in calls, work with Governor's Workforce Cabinet, and continue partnering with DORA and NGA to develop strategies to best address identified issues.

REGULATION/ OVERSIGHT	Consolidate oversight of physical, mental, and substance use disorder providers
	Use Policy Workgroup to develop strategies/processes to increase coordination among state departments regarding strategic goals around health and health care.
	Identify mechanisms to overcome individual agency approaches to rule-creation to reduce variation, duplication and/or conflict.
	Address state laws and regulations that impede integrated care delivery
	Examine building code regulations.
	Review scope of practice and licensure requirements.
	Address regulations/practices that impede reimbursement of integrated care.
	Work with HCPF to evaluate the need for potential Medicaid waivers or State Plan Amendments (i.e., Section 2703 Health Homes)


KEY ACTIVITIES
SECONDARY DRIVER
PRIMARY DRIVER
Population Health
Engage communities to reduce stigma, promote prevention, and remove barriers to accessing integrated care
Provider Education
Develop educational opportunities for providers that focus on screening, prevention, and special populations
Support for Community-Level Health Promotion Efforts
Support communities to coordinate local resources and employ strategies to reduce stigma, raise awareness, and promote health, based on local needs
Population Health Monitoring
Use public health data to track trends in the behavioral and physical health of the population as well as to identify areas of high burden and cost
Disseminate online Provider Education Modules to primary care providers
Identify and address key barriers to implementing SBIRT
Disseminate resources for behavioral health providers integrating into the primary care setting
Deploy Regional Health Connectors to coordinate activities between providers, the public health system, and community resources
Fund at least five Local Public Health Agencies to implement strategies that reduce stigma, increase screening, or promote behavioral health
Fund Regional Behavioral Health Collaboratives working on behavioral health disorder prevention
Work with state and local public health agencies to jointly advance regulatory initiatives that improve population health
Monitor health outcomes on a population health level related to 12 areas of behavioral and physical health

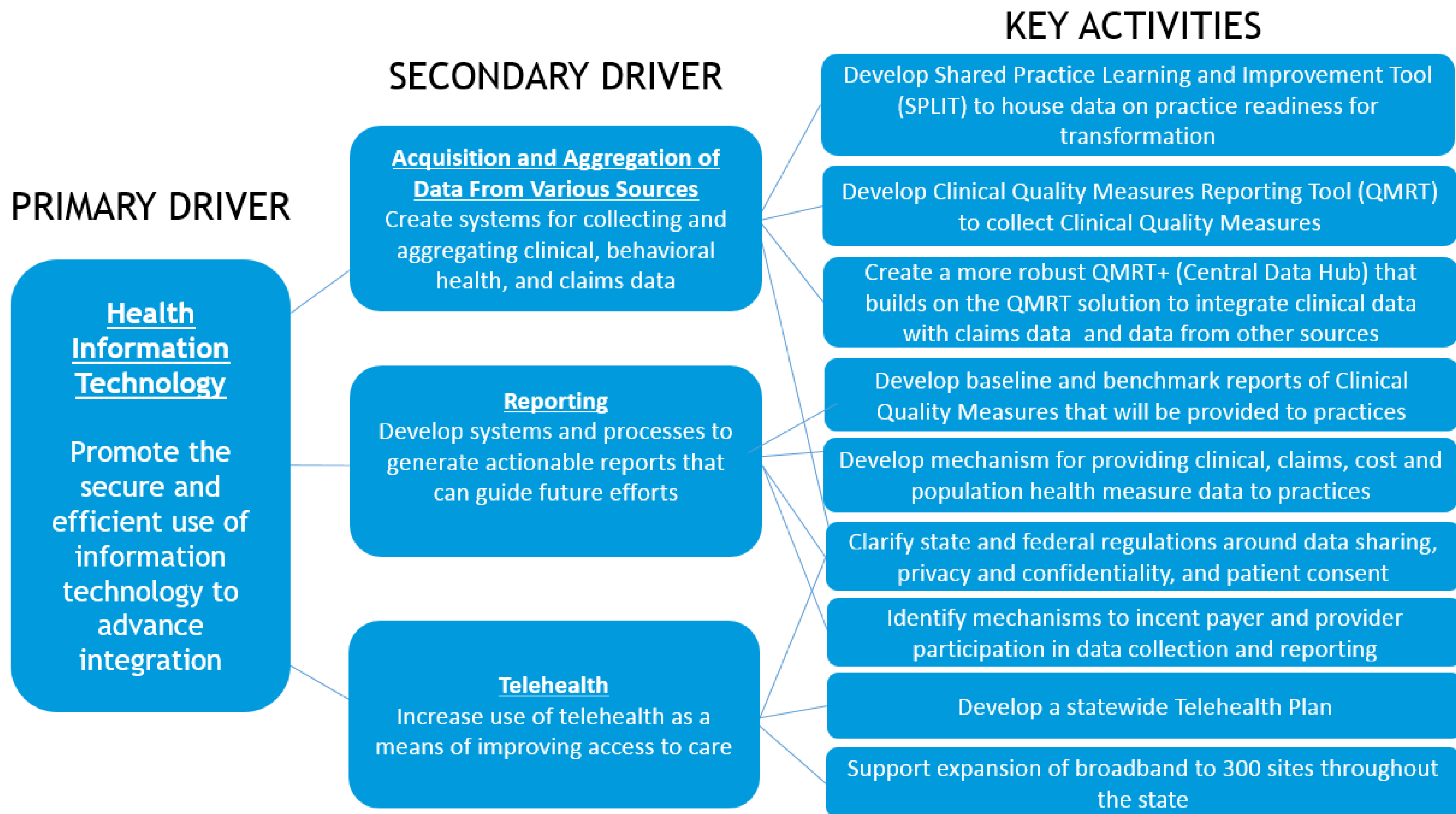
Primary Driver: Population Health

<table>
<tr><td rowspan="11"><u>PROVIDER EDUCATION</u>

Key Metrics:
# of Providers engaged in each of several provider education opportunities</td><td>Disseminate online Provider Education Modules to primary care providers</td></tr>
<tr><td>Colorado Department of Public Health and Environment (CDPHE) to design online training modules that address pregnancy-related depression, obesity & depression, and depression in men, and disseminate them to at least 100 primary care providers.</td></tr>
<tr><td>Office of Behavioral Health (OBH) to develop online courses related to substance use disorders, behavioral health in the senior population, and trauma-related issues, and disseminate them at least 100 primary care providers.</td></tr>
<tr><td>CDPHE to create a Provider Education Plan to guide dissemination of educational opportunities.</td></tr>
<tr><td>Identify and address key barriers to implementing SBIRT</td></tr>
<tr><td>OBH to conduct an environmental scan of practices in order to determine key barriers to implementing SBIRT and make recommendations on how to address these barriers.</td></tr>
<tr><td>Disseminate resources for Behavioral Health Providers integrating into the primary care setting</td></tr>
<tr><td>OBH to compile a resource outlining best practices for behavioral health providers working in the primary care setting.</td></tr>
<tr><td>OBH to develop a voluntary certificate program for behavioral health providers working in the primary care setting, to be completed by a minimum of 50 providers.</td></tr>
<tr><td>Collaborate with the Colorado Department of Regulatory Agencies Division of Professions and Occupations Licensing Boards.</td></tr>
</table>

SUPPORT FOR COMMUNITY-LEVEL HEALTH PROMOTION EFFORTS **Key Metrics: # of Regional Health Connectors deployed, # of Local Public Health Agencies and Regional Behavioral Health Collaboratives funded**	**Deploy Regional Health Connectors**
	Colorado Health Institute to deploy approximately 20 FTEs as Regional Health Connectors throughout state.
	Develop standardized training for Regional Health Connectors.
	Select host organizations to house Regional Health Connectors in local communities.
	Fund at least five Local Public Health Agencies (LPHAS) and Regional Behavioral Health Collaboratives to implement strategies that reduce stigma, increase screening, or promote behavioral health
	CDPHE and Denver Foundation to announce final selection of funded LPHAS and Regional Behavioral Health Collaboratives in January, 2016.
	CDPHE to disseminate funds to awardees and monitor progress toward goals.
	The SIM Office to broker introductions between funded LPHAs, Regional Health Connectors, and SIM-participating practices to foster partnership building.
	Advance regulatory initiatives that improve population health
	Partner with CDPHE to implement/achieve policy objectives outlined in the Healthy Colorado: Shaping a State of Health - Colorado's Plan for Improving Public Health and the Environment 2015-2019 report.
	Coordinate and align the administration and funding of prevention services.
	Address regulatory barriers in areas such as obesity, behavioral health, tobacco access and pricing, food access, diabetes, and environmental safety.

POPULATION HEALTH MONITORING **Key Metrics: Population health metrics outlined in the "Core Progress and Accountability Targets" section of the plan.**	**Monitor health outcomes on a population health level related to 12 areas of behavioral and physical health**
	CDPHE to provide Colorado SIM with updates on all population health metrics listed in the "Core Progress Metrics and Accountability Targets" section of the Operational Plan as they become available.
	CDPHE, in collaboration with the Colorado SIM Office, to develop an electronic, interactive display of population health metrics that can divide data based on demographics (county, age, etc.) to be used by practices, Local Public Health Agencies, and other relevant organizations to identify areas of high need.



KEY ACTIVITIES
SECONDARY DRIVER
PRIMARY DRIVER
Health Information Technology
Promote the secure and efficient use of information technology to advance integration
Acquisition and Aggregation of Data From Various Sources
Create systems for collecting and aggregating clinical, behavioral health, and claims data
Reporting
Develop systems and processes to generate actionable reports that can guide future efforts
Telehealth
Increase use of telehealth as a means of improving access to care
Develop Shared Practice Learning and Improvement Tool (SPLIT) to house data on practice readiness for transformation
Develop Clinical Quality Measures Reporting Tool (QMRT) to collect Clinical Quality Measures
Create a more robust QMRT+ (Central Data Hub) that builds on the QMRT solution to integrate clinical data with claims data and data from other sources
Develop baseline and benchmark reports of Clinical Quality Measures that will be provided to practices
Develop mechanism for providing clinical, claims, cost and population health measure data to practices
Clarify state and federal regulations around data sharing, privacy and confidentiality, and patient consent
Identify mechanisms to incent payer and provider participation in data collection and reporting
Develop a statewide Telehealth Plan
Support expansion of broadband to 300 sites throughout the state

Primary Driver: Health Information Technology

<table>
<tr><td rowspan="12"><u>ACQUISITION AND AGGREGATION OF DATA FROM VARIOUS SOURCES</u>

Key Metric: # of SIM Practicing utilizing SPLIT and QMRT effectively</td><td>Develop Shared Practice Learning and Improvement Tool (SPLIT) to house data on practice readiness for transformation</td></tr>
<tr><td>Design recommendations for SPLIT.</td></tr>
<tr><td>Train for Practice Transformation Organizations on use of SPLIT.</td></tr>
<tr><td>CDPHE to create a Provider Education Plan to guide dissemination of educational opportunities.</td></tr>
<tr><td>Develop Clinical Quality Measures Reporting Tool (QMRT) to collect Clinical Quality Measures</td></tr>
<tr><td>Select vendor for design of short-term QMRT.</td></tr>
<tr><td>Conduct initial testing and use of QMRT during first quarter of SIM practice transformation; ongoing enhancements thereafter.</td></tr>
<tr><td>Collect Clinical Quality Measures from SIM-participating practices via QMRT on quarterly basis.</td></tr>
<tr><td>Create robust QMRT+ (Central Data Hub) that builds on the QMRT solution to integrate clinical data with claims data and data from other sources</td></tr>
<tr><td>Convene Subject-Matter Experts to make a recommendation on infrastructure design.</td></tr>
<tr><td>Issue RFP to select vendor responsible for development of QMRT+.</td></tr>
<tr><td>Collect quarterly data via QMRT+.</td></tr>
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<table>
<tr><td rowspan="12"><u>REPORTING</u>

Key Metrics: # of practices receiving regular reports of Clinical Quality Measures; # of practices accessing practice-level dashboards</td><td>Develop baseline and benchmark reports of Clinical Quality Measures that will be provided to practices</td></tr>
<tr><td>Develop report to be provided back to practices with their Clinical Quality Measures, to include comparison to practice baseline over time.</td></tr>
<tr><td>Develop benchmark report that compares practices to performance of their peers.</td></tr>
<tr><td>Develop mechanism for providing clinical, claims, cost and population health measure data to practices</td></tr>
<tr><td>Work with stakeholders to determine fields that are most useful to include for reporting back to practices.</td></tr>
<tr><td>Build display capabilities into QMRT+ solution.</td></tr>
<tr><td>Clarify state and federal regulations around data sharing, privacy and confidentiality, and patient consent</td></tr>
<tr><td>Evaluate policy actions including, but not limited to: Subscription subsidies to health technology platforms and improving a patient-centric approach to data sharing across public and private care settings.</td></tr>
<tr><td>Identify mechanisms to incent payer and provider participation in data collection and reporting</td></tr>
<tr><td>Identify qualifying characteristics of high-performing SIM “All-Star” practices, selected for their exceptional commitment to collecting and using data.</td></tr>
<tr><td>Identify incentives/rewards offered to All-Star practices.</td></tr>
<tr><td>Select of All-Star practices.</td></tr>
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<table>
<tr><td rowspan="7"><u>TELEHEALTH</u>

Key Metrics: # of practices with expanded broadband access</td><td>Develop a statewide Telehealth Plan</td></tr>
<tr><td>Release RFP for selection of telehealth strategy vendor and select vendor.</td></tr>
<tr><td>Vendor to develop Statewide Telehealth Plan.</td></tr>
<tr><td>Implement telehealth strategy as outlined in plan.</td></tr>
<tr><td>Support expansion of broadband to 300 sites throughout the state</td></tr>
<tr><td>Work with Colorado Telehealth Network (CTN) to identify potential site for expanded broadband.</td></tr>
<tr><td>CTN to assist sites in acquiring subsidies and navigating process of expanding broadband access.</td></tr>
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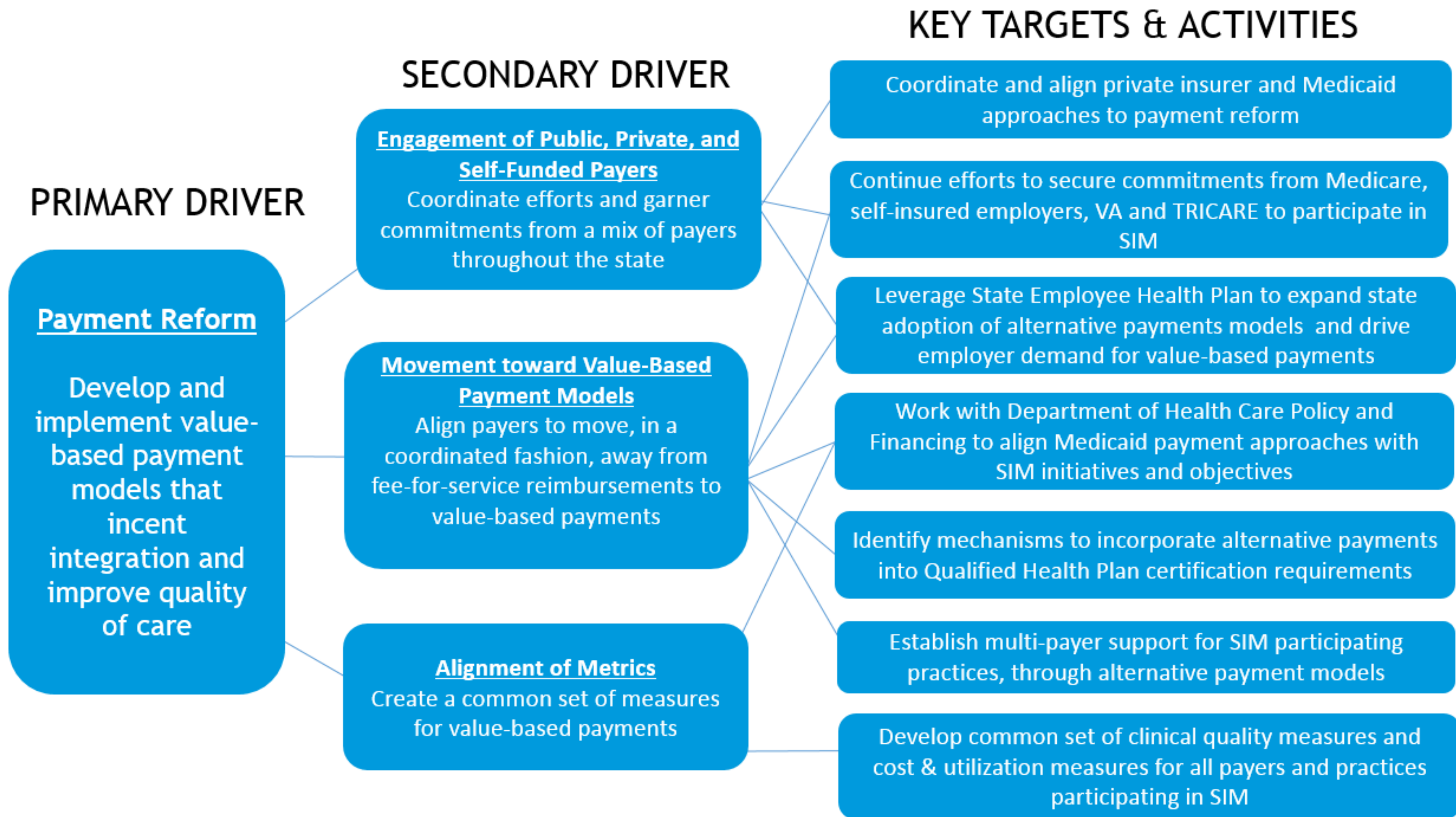


KEY TARGETS & ACTIVITIES
SECONDARY DRIVER
PRIMARY DRIVER
Payment Reform
Develop and implement value-based payment models that incent integration and improve quality of care
Engagement of Public, Private, and Self-Funded Payers
Coordinate efforts and garner commitments from a mix of payers throughout the state
Movement toward Value-Based Payment Models
Align payers to move, in a coordinated fashion, away from fee-for-service reimbursements to value-based payments
Alignment of Metrics
Create a common set of measures for value-based payments
Coordinate and align private insurer and Medicaid approaches to payment reform
Continue efforts to secure commitments from Medicare, self-insured employers, VA and TRICARE to participate in SIM
Leverage State Employee Health Plan to expand state adoption of alternative payments models and drive employer demand for value-based payments
Work with Department of Health Care Policy and Financing to align Medicaid payment approaches with SIM initiatives and objectives
Identify mechanisms to incorporate alternative payments into Qualified Health Plan certification requirements
Establish multi-payer support for SIM participating practices, through alternative payment models
Develop common set of clinical quality measures and cost & utilization measures for all payers and practices participating in SIM

Primary Driver: Payment Reform

<table>
<tr><td rowspan="10"><u>ENGAGEMENT OF PUBLIC, PRIVATE, AND SELF-FUNDED PAYERS</u>

Key Metric:
# of payers participating in SIM</td><td>Coordinate and align private insurer and Medicaid approaches to payment reform</td></tr>
<tr><td>Leverage Multi Payer Collaborative and SIM Payment Reform Workgroup to align efforts of public and private payers involved in SIM.</td></tr>
<tr><td>Payers to sign Memorandum of Understanding with SIM Office outlining commitment to Alternative Payment Models.</td></tr>
<tr><td>Payers submit description of payment models that will be used to support SIM practices to the SIM Office as an Addendum to MOU.</td></tr>
<tr><td>Continue efforts to secure commitments from Medicare, self-insured employers, VA and TRICARE to participate in SIM</td></tr>
<tr><td>Engage with CMS in ongoing discussions of Medicare participation in SIM.</td></tr>
<tr><td>SIM Office will engage with the Colorado Business Group on Health, an organization representing 17 self-funded groups from across the state, to explore the expansion of integrated care and alternative payment models to this market segment.</td></tr>
<tr><td>Leverage State Employee Health Plan to expand state adoption of alternative payments models and drive employer demand for value-based payments</td></tr>
<tr><td>SIM Office will continue to work with the Department of Personnel Administration (DPA) regarding the use of contractual language/stipulations regarding integrated care and alternative payment models as part of the state employee health plan re-procurement process.</td></tr>
</table>

MOVEMENT TOWARD VALUE-BASED PAYMENT MODELS **Key Metric: # of practices supported by an alternative payment model**	**Work with Department of Health Care Policy and Financing to align Medicaid payment approaches with SIM initiatives and objectives**
	SIM Office will participate in HCPF planning and discussions around proposed payment models for Phase II of the ACC and the CCBHC grant, and other proposed initiatives as they arise.
	Identify mechanisms to incorporate alternative payments into Qualified Health Plan certification requirements
	Work with DOI to include information about integrated care delivery and the use of value-based payments as part of health benefit plan filing requirements.
	Work with Connect for Health Colorado to determine a method for highlighting plans that offer a high degree of integrated care on the health plan shopping website.
	Payers support SIM-participating practices with alternative payment models
	SIM Office will engage with the University of Colorado and the payers around selection processes for practice cohorts 2 and 3.
	Payers to review practices accepted into SIM cohorts to determine practices within their provider networks they will support with alternative payment models.
	Payers to reach out to supported practices and negotiate agreements around alternative payment models.

ALIGNMENT OF METRICS **Key Metric: # of practices and payers reporting on common metric set**	**All participating payers utilize common set of clinical quality measures (CQMs) and cost & utilization measures**
	Payers will work with internal informatics teams, SIM Office, the SIM Evaluation Specialist, and the Selected SIM Evaluation Vendor to establish accountability targets for the number of lives covered by alternative payment models through SIM.
	Work with payers to define numerators and denominators used for metric reporting.
	SIM Office will work with CMMI to ensure data being gathered meets the needs of RTI.

Alignment of Major Activities Across SIM Workgroups

HIT | Practice Transformation | Population Health | Payment Reform | Policy | Workforce | Consumer Engagement | Evaluation

Clinical quality measures (QMRT)

Cost & utilization data

Central data hub (QMRT+)

Health information sharing (behavioral health data, 42 C.F.R. Part 2; patient access to medical records

Measure alignment (across federal and state initiatives)

Regional Health Connectors

Building Blocks/Practice Milestones

Licensure, scope of practice

Core Progress Metrics and Accountability Targets

The tables below contain metric descriptions, numerator and denominator definitions, and reporting frequency related to model participation, payer participation, and model performance metrics.

Model Participation

Payment Reform

Colorado SIM is working with participating payers to identify the alternative payment models supported by SIM. To date, payers have committed to reporting on the number of beneficiaries and practices participating in alternative payment models supported by SIM. Payers are working internally among their respective organizations to determine if they have the capacity to report beneficiaries and practices by *each* alternative payment model categorized by the Center for Medicare and Medicaid Service's (CMS's) four categories. Payers will also identify whether they can report the number of providers participating in an alternative payment model supported by SIM, in addition to beneficiaries and practices. Payers have committed to reporting their ability to submit this level of data by July 1, 2016.

For the purpose of metrics related to participation in alternative payment models, Colorado SIM is defining "beneficiaries" as attributed lives for each payer. The SIM Office is working with payers and their informatics teams to determine the attribution methodologies that will be utilized for SIM, along with refined definitions for numerators and denominators. Denominators are not being defined as "targeted for inclusion" at this time, as payers first need to know which practices will be included in the SIM practice transformation cohort. Since Colorado SIM is targeting 80 percent of Colorado residents versus a specific subset of the population, the denominator for beneficiaries impacted is being defined as the total state population. Payers have committed to reporting on this data twice per year. The OHSU payer facilitation vendor has conducted a survey among all participating payers to identify baseline information. Once alternative payment models are finalized, the SIM Office will utilize the results of the survey and work with the Multi-Payer Collaborative (MPC) to provide baseline data and set biannual accountability targets for participation in alternative payment models. Please see the ***Payment and Service Delivery Models*** section of the Operational Plan for a complete description of the MPC.

Practice Transformation

Colorado SIM has added state-specific metrics around participation in practice transformation technical assistance and aims to support a total of 400 primary care practices and four CMHCs. Quarterly

accountability targets are based on financial projections submitted as a part of the proposal that include practices participating in SIM practice transformation technical assistance activities and include physicians only. Beneficiaries impacted include all beneficiaries attributed to practices participating in the SIM practice transformation cohort. Colorado SIM aims to on-board 100 primary care practices and four CMHCs in Year 1 of SIM implementation, 150 primary care practices in Year 2, and 150 primary care practices in Year 3. According to actuarial estimates performed by Milliman, this will allow Colorado SIM to reach 400 primary care providers and 760,000 beneficiaries by Year 1; 1,000 primary care providers and 1,900,000 beneficiaries by Year 2; and 1,600 primary care providers and 3,040,000 beneficiaries by Year 3 as part of practice transformation efforts. As part of the bi-directional efforts, 30 providers will participate within the four CMHCs and will reach 5,000 beneficiaries.

Population Health

Colorado SIM has added state-specific metrics around population health efforts related to LPHA, BHRCs, and provider education participation. Colorado SIM will work with CDPHE and the selected evaluation vendor to identify quarterly accountability targets for population health efforts. Since these efforts are new, baseline data will be identified during the first reporting period for SIM.

The model participation metrics for LPHAs and BHRCs capture the organizations that are funded as the denominator and those that are funded and actively implementing strategies in the community as the numerator. This reflects the ramp-up period in the first year for the LPHAs and BHRCs to finalize strategies, solidify partnerships, and plan implementation. The numerator reflects the LPHAs and BHRCs that have in place an executed contract, and have successfully completed the planning phase and moved into the implementation phase (which includes execution of necessary BAAs, MOUs, solidifying partners, etc.). Once funded LPHAs and BHRCs have all moved into the implementation phase, it is expected that the numerator and denominator remain the same unless one of the LPHAs or BHRCs is no longer able to implement its strategies.

HIT

Colorado SIM has added state-specific metrics around HIT efforts related to telehealth and practice-level data reporting. Since Health Information Exchange (HIE) expansion is not a focus of Colorado SIM, these metrics will be more useful to inform Colorado's model implementation. The Colorado Telehealth Network (CTN), the federally designated provider for Colorado's health care broadband infrastructure, will lead the effort to enable 300 practices for telehealth. CTN will enable 25 practices per quarter over

the course of the three-year model test. Practice-level data reporting targets align with the number of practices that Colorado SIM aims to reach in the practice transformation cohorts.

Payer Participation

Colorado SIM is working with participating payers to identify the alternative payment models supported by SIM. To date, payers have committed to reporting participation metrics by payer on a de-identified basis. While payers have committed to reporting according to CMS's four categories, payers are working internally among their organizations to determine if they can report number of beneficiaries and percentage of payments to providers by *each* alternative payment model. Payers have committed to reporting their ability to submit this level of data by July 1, 2016.

Depending on the outcome of payer decisions to report data by alternative payment model, Colorado SIM may need to revisit the chosen denominator. At this point in time, payers have committed to reporting with the entire state population as the denominator. Since Colorado SIM aims to reach 80% of the entire state population (as opposed to any specific target population), this may be the best denominator in helping Colorado SIM track progress toward the overarching goal.

Colorado SIM is taking a collaborative approach to payer participation, and leveraging the commitments expressed by public and private payers in the Multi-Payer Collaborative. To date, payers' cooperation with one another and with Colorado SIM has been entirely voluntary, based on a mutual desire to strengthen primary care in Colorado. Colorado's approach to dealing with industry, both historically and under the leadership of Governor Hickenlooper, has been one that favors engagement and discussion to reach consensus or mutual agreement, rather than regulation. Colorado SIM believes it will be able to achieve its objectives and goals around payment reform through a continued collaboration and discussion with public and private payers.

As SIM progresses over the course of the award period and best practices are identified both in terms of integrated care delivery and alternative payment models, the state may seek to disseminate or codify such practices through regulation or guidance, but the exact form or mechanisms that may be employed have yet to be determined.

Model Performance

Utilization

Colorado SIM will report on seven utilization metrics related to clinical and behavioral health on a quarterly basis. Milliman will receive a quarterly All Payer Claims Data (APCD) data stream from the

Center for Improving Value in Health Care (CIVHC) to provide utilization data to CMS and back to individual practices. CIVHC is establishing a baseline for utilization metrics based on APCD data, and will submit this deliverable January 31, 2016. Once a baseline is established, the SIM Office will work with CIVHC, the selected evaluation vendor, and stakeholders to identify accountability targets related to utilization.

Cost of Care

Colorado SIM will report on two metrics to measure cost of care: total cost of care and out-of-pocket expenditures for consumers. This reflects stakeholder input that Colorado SIM must monitor health care cost trends not only for health plans, but also for whether or not the costs are shifted to consumers. Out-of-pocket expenditures will be calculated from claims data within the APCD. This includes the "member responsibility" portion documented in the explanation of benefits and includes coinsurance, co-pays and deductibles.

Milliman will receive a quarterly APCD data stream from CIVHC to provide cost of care data to CMS and back to individual practices. CIVHC is establishing a baseline for cost of care metrics based on APCD data and will submit this deliverable January 31, 2016. Once baseline is established, the SIM Office will work with CIVHC, the selected evaluation vendor, and stakeholders to identify accountability targets related to cost of care.

Quality

In the proposal, Colorado SIM identified 18 domains to monitor clinical quality. Stakeholders have recommended specific measures within each of the domains to monitor over the course of SIM. These measures align with CPCI and will largely be reported by practices on a quarterly basis. Two of the measures (breast cancer screening and colorectal screening) will be pulled directly from claims data. In order to align with NQF guidelines, Colorado SIM is placing a hold on the original Ischemic Vascular Disease (IVD) and Diabetes LDL management and control measures until NQF releases final measures. Practices will not be required to report on the IVD and LDL measures until Colorado SIM has received final NQF guidance. The original tobacco measure will not be reported separately, but is captured as part of the SUD measure. The remaining CQMs will be reported by practices on a quarterly basis. Three core measures (flu, asthma, and obesity) will be reported by all practices. Three core measures (pediatric depression screening, maternal depression, and developmental screening) will be reported by pediatric practices only. Four core measures (breast cancer screening, colorectal screening, adult depression screening, and SUD screening) will be reported by family/adult practices only. The remaining

five measures are optional and will be phased in over the two years of participation in the practice transformation cohort.

The consumer experience measure is not yet determined. Colorado SIM Workgroup stakeholders have reviewed questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) tool and discussed its utility for the purpose of measuring consumer experience. Stakeholders have recommended that the SIM Office work with the selected evaluation vendor to determine a different measure and means for capturing consumer experience, satisfaction and access to care. Previous experiences with the CAHPS tool in Colorado have shown difficulties with its ability to capture change, particularly to inform rapid-cycle improvements or realize significant movement within the measure. With the general nature of the questions, it is not an ideal tool for measuring consumer experience related Colorado's model of integrated care. Additionally, it is challenging to attribute the outcomes to SIM efforts, as CAHPS data is not collected at the practice level. Once the selected state evaluation vendor is on board, opportunities to measure care experience for SIM participating practices will be explored. The measures for care experience, along with numerator and denominator definitions, are being discussed and finalized in conjunction with the MPC, the Consumer Engagement Workgroup, and the CMMI federal evaluator. The Evaluation and Consumer Engagement Workgroups are scheduling a joint Workgroup meeting in January to recommend a care experience measure. The recommendation will then go to the Steering Committee for final approval. The SIM Office will work with the state evaluator to put the mechanisms in place to report on the selected care experience measure by the first quarterly reporting period.

Colorado SIM has contracted with CIVHC to establish a set of claims-based proxy measures from the APCD related to the CQMs. Baseline data for the established proxy measures will be submitted on January 31, 2016. The first quarterly report by practices participating in the practice transformation cohort will also serve as a baseline for participating SIM practices. Once a baseline is establish, the SIM Office will work with the evaluation vendor and stakeholders to identify accountability targets related to clinical quality.

Population Health

In the proposal, Colorado SIM identified 12 domains to monitor population health. These 12 domains align with Colorado's Winnable Battles and the SIM CQMs. Specific population health metrics were identified by CDPHE in conjunction with stakeholders. Population health measures will be pulled from existing surveys and reported on an annual basis. Data for the most recent year for each population

health measure is included in the metrics table below. Colorado SIM does not expect to see significant changes in the population health outcomes measures over the course of the three-year model test.

Access to Care

Colorado SIM, in conjunction with stakeholders, has identified four claims-based access-to-care measures. Prevention Quality Indicators are composites of ambulatory care sensitive conditions that are used to measure access to care. The selected evaluation vendor will utilize Agency for Healthcare Research and Quality (AHRQ) methodology to calculate the PQI measures on a quarterly basis, using claims data from the APCD. Colorado SIM will also work with the selected evaluation vendor to identify additional access to care measures, specifically related to access to integrated care.

State Health Landscape

Colorado SIM understands the importance of supporting broader Health and Human Services (HHS) goals and will work towards tracking participation in all alternative payment models across the state. Initially, Colorado SIM will focus on tracking participation in SIM-supported alternative payment models and will explore strategies to track participation in all statewide alternative payment models.

Baseline and Accountability Targets

The selected evaluation vendor will deliver baseline data for all identified metrics within the first quarter of SIM implementation, with a targeted deliverable data of April 30, 2016. Colorado SIM is planning to utilize claims-based proxy measures for each of the clinical quality measures to contribute to baseline data. CIVHC has developed specifications and is building queries to submit a baseline report of the proxy measures in January. Baseline data for population health was pulled from the most recent year's survey data, and is included in the Model Participation Metrics table below. Many of the model participation metrics are new implementations as part of SIM and will not have a baseline; in these instances, SIM will be able to track progress according to accountability targets. For any additional evaluation metrics, Colorado SIM will work with the state and federal evaluator to identify appropriate baseline data.

Once baseline data for measures has been established, SIM will work with the state evaluation contractor, the Evaluation Workgroup and relevant stakeholders to identify accountability targets for core metrics. The SIM Office anticipates that accountability targets will be established by the first quarterly report in May. The selected evaluation vendor will then work with Milliman and stakeholders to develop methodology for projecting targets and collecting data on a quarterly basis to report on core metrics for the remaining SIM components.

The SIM Office is using NQF endorsed methodologies wherever possible for the quality and utilization measures. NQF has completed an update of the measurement standards, and their specifications are updated to reflect the conversion of the national medical coding system from ICD-9 to ICD-10 and the use of clinical code sets for the electronic quality and performance measurement data. If NQF releases updated specifications over the course of SIM, the SIM Office will work with CMMI, the federal evaluator, and stakeholders to determine a plan for transitioning.

Ongoing identification and refinement of measures will take place in the Evaluation Workgroup. Once the state evaluator is on board, the selected vendor will work with the federal evaluator, SIM Office and Evaluation Workgroup to finalize measures. The central repository of measures is anticipated to be delivered to the SIM Office by April 2016.

Model Participation Metrics

Metric Area	Metric Title	Metric Definition/Description	Numerator Definition	Denominator Definition	Reporting Frequency	Payment Taxonomy Category (2-4)
Payment Reform						
Model Participation - Beneficiaries	Population Impacted by SIM (all payment models)	Total number of beneficiaries (individuals) receiving care through **any value-based purchasing and alternative payment model** supported by SIM	Total number of beneficiaries (individuals) receiving care through **any value-based purchasing and alternative payment model** supported by SIM	Total State population	Biannually	
Model Participation - Provider Organizations	Provider Organizations Participating in SIM (all payment models)	The total number of provider organizations participating in **any value-based purchasing and alternative payment model** supported by SIM	Total number of provider organizations participating in **any value-based purchasing and alternative payment model** supported by SIM	Total number of provider organizations in the State	Biannually	
Practice transformation						
Model Participation - Beneficiaries	Population Impacted by SIM (practice transformation)	The total number of beneficiaries (individuals) receiving care through **practices participating in practice transformation** supported by SIM	The total number of beneficiaries (individuals) receiving care through **practices participating in practice transformation** supported by SIM	Total number of beneficiaries **targeted** for inclusion in **practice transformation** supported by SIM	Quarterly	N/A
Model Participation - Providers	Providers Participating in SIM (practice transformation)	The total number of providers participating in **practice transformation technical assistance** supported by SIM	The total number of providers participating in **practice transformation technical assistance** supported by SIM	Total number of providers **targeted** for inclusion in **practice transformation** supported by SIM	Quarterly	N/A
Model Participation - Provider Organizations	Provider Organizations Participating in SIM (practice transformation)	The total number of provider organizations participating in **practice transformation technical assistance** supported by SIM	The total number of provider organizations participating in **practice transformation technical assistance** supported by SIM	Total number of provider organizations **targeted** for inclusion in **practice transformation** supported by SIM	Quarterly	N/A

Population Health						
Model Participation – LPHAs	Communities Impacted by SIM (population health)	Total number of **LPHAs** implementing **behavioral health and wellness initiatives** in their communities supported by SIM	Total number of **LPHAs implementing a strategy** to address behavioral health and wellness in their communities	Total number of **LPHAs funded** to implement a behavioral health and wellness initiative in their communities	Quarterly	N/A
Model Participation – Behavioral Health Regional Collaboratives	Communities Impacted by SIM (population health)	Total number of **Behavioral Health Regional Collaboratives (BHRCs)** implementing **behavioral health prevention strategies** in their communities supported by SIM	Total number of **BHRCs implementing** behavioral health prevention strategies in their communities	Total number of **BHRCs funded** to implement a behavioral health prevention strategy in their communities	Quarterly	N/A
Model Participation – Providers	Providers participating in SIM (population health)	Total number of **providers** participating in **educational activities** supported by SIM	Total number of **providers participating** in **educational activities** supported by SIM	Total number of **providers targeted** for inclusion in **educational activities** supported by SIM	Quarterly	N/A
HIT						
Model Participation – Provider organizations	Provider organizations enabled for telehealth	The total number of provider organizations **enabled for telehealth** supported by SIM	The total number of provider organizations **enabled** for **telehealth** supported by SIM	The total number of provider organizations **targeted** for **telehealth** supported by SIM	Quarterly	N/A
Model Participation - Provider Organizations	Provider Organizations participating in SIM (data reporting)	The total number of provider organizations **submitting data on CQMs** supported by SIM	The total number of provider organizations **submitting data on CQMs** supported by SIM	The total number of provider organizations **targeted** to **submit data on CQMs** supported by SIM	Quarterly	N/A

Payer Participation Metrics

	Category 1 Payments: Fee-for-service with no link of payment to quality		**Category 2 Payments: Payment Linked to Quality**		**Category 3 Payment: Alternative Payment Models**		**Category 4 Payment: Population-based Payment**	
Payer ID	A. Total Number of Beneficiaries	B. Total % of Payments to Providers	A. Total Number of Beneficiaries	B. Total % of Payments to Providers	A. Total Number of Beneficiaries	B. Total % of Payments to Providers	A. Total Number of Beneficiaries	B. Total % of Payments to Providers
Payer A								
Payer B (et. al.)								

Model Performance Metrics

Metric Area	Metric Title	Metric Definition/Description	Numerator Definition	Denominator Definition	NQF#	Notes	Reporting Frequency	Alignment to Other CMS Programs
Utilization								
Model Performance - Utilization	Admissions	The number of discharges for any cause per 100,000 population, age 18 years and older, in a Metro Area or county in a one year time period.	All discharges age 18 years and older.	Population age 18 years and older in Metro Area or county.	CMS	Pulled from Health Care Innovation Awards: Recommended Awardee Self-Monitoring Measures CMS guidance document	Quarterly	
Model Performance - Utilization	Psychiatric Admissions	The total number of discharges from a hospital episode for treatment of a mental health diagnosis per 1,000 members, by age group and total population. The discharge must occur in the period of measurement.	Total number of members during the specified fiscal year (12-month period) per HEDIS age group.	All discharges from a hospital episode for treatment of a covered mental health diagnosis per HEDIS age group.	CMS	Stratify by psychiatric conditions; pulled from Health Care Innovation Awards: Recommended Awardee Self-Monitoring Measures CMS guidance document	Quarterly	
Model Performance - Utilization	Readmissions	This measure estimates the hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older. The measure reports a single summary RSRR, derived from the volume-weighted results of five different models, one	The outcome for this measure is 30-day readmission. We define readmission as an inpatient admission for any cause, with the exception of certain planned readmissions, within 30 days from the date of discharge from an eligible index admission. If a patient has more than one	The target population for this measure is patients aged 18 years and older discharged from the hospital with a complete claims history for the 12 months prior to admission. The measure is currently publicly reported by CMS for those 65 years and older who	1789	NQF 1768 all-cause readmissions measure utilized in other CMS initiatives and guidance. CO SIM will continue to work across state-level initiatives to align measures.	Quarterly	CPCI; ACC MMP

		for each of the following specialty cohorts (groups of discharge condition categories or procedure categories): surgery/gynecology, general medicine, cardiorespiratory, cardiovascular, and neurology. The measure also indicates the hospital standardized risk ratios (SRR) for each of these five specialty cohorts.	unplanned admission within 30 days of discharge from the index admission, only the first one is counted as a readmission.	are Medicare Fee for Service (FFS) beneficiaries admitted to non-federal hospitals.				
Model Performance - Utilization	Psychiatric Readmissions	7-, 30- and 90-Day Hospital Readmission Rate (Psychiatric or Substance Abuse) Hospital readmission rates are widely used as a proxy for relapse or complications following an inpatient stay for a psychiatric disorder. Reports support the use of readmission rates in quality improvement activities, and have led to improved discharge planning and linkages between inpatient and outpatient care.	The number of patients discharged from an inpatient acute mental health or substance abuse facility within 7, 30 and 90 days from the date of discharge from an eligible index admission.	The target population for this measure is patients aged 18 years and older discharged from the hospital with a complete claims history for the 12 months prior to admission.	1789	Stratify by psychiatric conditions; NQF 1768 all-cause readmissions measure utilized in other CMS initiatives and guidance. CO SIM will continue to work across state-level initiatives to align measures.	Quarterly	
Model Performance - Utilization	Emergency Department (ED) Rate	Hospital ED Visit Rate, by Condition (as appropriate).	All participating patients with a given condition, sum the number of ED visits.	Count number of participating patients with a given condition. Includes ED observation unit visit rates.	CMS	Pulled from Health Care Innovation Awards: Recommended Awardee Self-Monitoring Measures CMS guidance document	Quarterly	ACC; ACC MMP

Model Performance – Utilization	Psychiatric ED Rate	Hospital ED Visit Rate, for a psychiatric condition (as appropriate).	All participating patients with a psychiatric condition, sum the number of ED visits.	Count number of participating patients with a psychiatric condition. Includes ED observation unit visit rates.	CMS	Stratify by psychiatric conditions; pulled from Health Care Innovation Awards: Recommended Awardee Self-Monitoring Measures CMS guidance document	Quarterly	
Model Performance – Utilization	Follow-Up after Hospitalization for Mental Illness	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported: the percentage of discharges for which the patient received follow-up within 30 days of discharge; the percentage of discharges for which the patient received follow-up within 7 days of discharge.	30-Day Follow-Up: An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge. 7-Day Follow-Up: An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge.	Patients 6 years and older as of the date of discharge who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (e.g., January 1 to December 1).	0576		Quarterly	

Cost of care								
Model Performance - Cost	Total Cost of Care Population-based Per-member per-month (PMPM) Index	Total Cost Index (TCI) is a measure of a primary care provider's risk-adjusted cost effectiveness at managing the population they care for. TCI includes all costs associated with treating members, including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary, and behavioral health services.	Count the total dollar amounts "allowed" by payers for individuals 18 years of age or older during the 12 month measurement period, and divide by 12.	Count the number of individuals (with and without spending), and divide by 12.	CMS	NQF 1604 is work in progress; pulled from Health Care Innovation Awards: Recommended Awardee Self-Monitoring Measures CMS guidance document	Quarterly	
Model Performance - Cost	Out-of- Pocket Expenditures for Consumers	The Consumer Out-of-Pocket Expenditure summarizes the relative cost to consumers, in dollars, adjudicated as "member responsibility," including copays, coinsurance, and deductibles.	Count the total sum of member-responsible dollar amounts, for individuals 18 years of age and older, during the selected 12-month measurement period.	Count the number of individuals with spending, 18 years of age and older, during the selected 12-month measurement period.			Quarterly	
Quality								
Model Performance - Quality	Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer	One or more mammograms during the measurement year or the year prior to the measurement year.	Women 42–69 years of age as of Dec 31 of the measurement year (note: this denominator statement captures women age 40-69 years).	0031	Reported by claims	Quarterly	CPCI; Transforming Clinical Practices Initiative (TCPI); Meaningful Use
Model Performance - Quality	Colorectal Screening	The percentage of patients 50–75 years of age who had appropriate screening for colorectal cancer.	One or more screenings for colorectal cancer. Any of the following meet criteria: fecal occult blood test during the measurement year; flexible sigmoidoscopy	Patients 51–75 years of age as of the end of the measurement year.	0034	Reported by claims	Quarterly	CPCI; TCPI; Meaningful Use

			during the measurement year or the four years prior to the measurement year; colonoscopy during the measurement year or the nine years prior to the measurement year.					
Model Performance - Quality	SUD Screening	Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use.	Patients who received the following substance use screenings at least once within the last 24 months.	All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the 12 month measurement period.	2597	Composite measure that includes tobacco (removed as separately-reported measure from proposal); self-reported by practice.	Quarterly	CO Winnable Battles
Model Performance - Quality	Flu	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization.	All patients aged 6 months and older seen for a visit between October 1 and March 31.	0041	Reported by practice EHR	Quarterly	CPCI; Meaningful Use
Model Performance - Quality	Asthma	The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.	The number of patients who were dispensed at least one prescription for an asthma controller medication during the measurement year.	Patients 5-64 years of age by the end of the measurement year who were identified as having persistent asthma.	0036	Reported by practice EHR	Quarterly	CPCI; TCPI
Model Performance - Quality	Obesity	0421: Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is	0421: Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal	0421: All patients aged 18 years and older with at least one eligible encounter during the measurement period.	0421 0024	Reported by practice EHR; 0421 for adults or 0024 for children/ adolescents	Quarterly	CPCI; TCPI; CO Winnable Battles

		outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18 – 64 years BMI > or = 18.5 and < 25 0024: Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: body mass index (BMI) percentile documentation, counseling for nutrition, counseling for physical activity	parameters, follow-up is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters. 0024: The percentage of patients who had evidence of a Body mass index (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	0024: Patients 3-17 years of age with at least one outpatient visit with a PCP or OB-GYN during the measurement year.				
Model Performance - Quality	Depression Screening	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.	Patient's screening for clinical depression using an age-appropriate standardized tool AND follow-up plan is documented.	All patients aged 12 years and older with at least one eligible encounter during the measurement year.	0418	Reported by practice EHR; utilizing new spec under consideration	Quarterly	CPCI; TCPI; ACC MMP; CO Winnable Battles
Model Performance - Quality	Maternal Depression	The percentage of children 6 months of age who had documentation of a maternal depression screening for the mother.	Children who had documentation of a maternal depression screening for the mother at least once between 0 and 6 months of life.	Children with a visit who turned 6 months of age in the measurement year.	1401	Reported by practice EHR	Quarterly	CPCI; TCPI; CO Winnable Battles

Model Performance - Quality	Developmental Screening	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age, and by 36 months of age.	The numerator identifies children who were screened for risk of developmental, behavioral, and social delays using a standardized tool. National recommendations call for children to be screened at the 9-, 18-, and 24- OR 30-month well visits to ensure periodic screening in the first, second, and third years of life. The measure is based on three, age-specific indicators.	Children who meet the following eligibility requirement: Age: Children who turn 1, 2, or 3 years of age between January 1 and December 31 of the measurement year.	1448	Self-reported by practice	Quarterly	CO Winnable Battles
Model Performance - Quality	Anxiety	Percentage of patients aged 12 years and older screened for anxiety using GAD-7 tool AND follow-up plan documented	Patient's screening for anxiety using GAD-7 tool AND follow-up plan is documented	All patients aged 12 years and older	N/A	Self-reported by practice	Quarterly	SHAPE; CO Winnable Battles
Model Performance - Quality	Hypertension	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the	Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.	0018	Partial claims (diagnosis only); partial reported by practice EHR (BP)	Quarterly	CPCI; TCPI; Meaningful Use

			representative BP must be identified.					
Model Performance - Quality	Diabetes: comprehensive care	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.	Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement year. The outcome is an out of range result of an HbA1c test, indicating poor control of diabetes.	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.	0059	Partial claims (diagnosis and if hba1c occurred);partial reported by practice EHR (HbA1c level)	Quarterly	CPCI; TCPI; Meaningful Use
Model Performance - Quality	Diabetes: blood pressure management	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) whose most recent blood pressure level taken during the measurement year is <140/90 mm Hg.	Patients whose most recent blood pressure level was <140/90 mm Hg during the measurement year.	Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.	0061	Self-reported by practice	Quarterly	CPCI; TCPI; Meaningful Use
Model Performance - Quality	Safety	This is a clinical process measure that assesses falls prevention in older adults. The measure has three rates: A) Screening for Future Fall Risk: Percentage of patients aged 65 years of age and older who were screened for future fall risk at least once within 12 months. B) Falls: Risk Assessment:	This measure has three rates. The numerators for the three rates are as follows: A) Screening for Future Fall Risk: Patients who were screened for future fall risk at last once within 12 months. B) Falls: Risk Assessment: Patients who had a risk assessment for falls	A) Screening for Future Fall Risk: All patients aged 65 years and older. B & C) Risk Assessment for Falls & Plan of Care for Falls: All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or	0101	Reported by practice EHR	Quarterly	CPCI; CO Winnable Battles

		Percentage of patients aged 65 years of age and older with a history of falls who had a risk assessment for falls completed within 12 months. C) Plan of Care for Falls: Percentage of patients aged 65 years of age and older with a history of falls who had a plan of care for falls documented within 12 months.	completed within 12 months. C) Plan of Care for Falls: Patients with a plan of care for falls documented within 12 months.	any fall with injury in the past year).				
Model Performance - Quality	Care Experience	*Measure TBD*						
Access to care								
Model Performance – Access to Care	Prevention Quality Chronic Composite	Prevention Quality Indicators (PQI) composite of chronic conditions per 100,000 population, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, and diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure.	Discharges, for patients ages 18 years and older, for conditions listed in metric definition. Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the PQIs are counted only once in the composite numerator.	Population ages 18 years and older in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.	AHRQ		Annually	

Model Performance – Access to Care	Prevention Quality Acute Composite	Prevention Quality Indicators (PQI) composite of acute conditions per 100,000 population, ages 18 years and older. Includes admissions with a principal diagnosis of one of the following conditions: dehydration, bacterial pneumonia, or urinary tract infection.	Discharges, for patients ages 18 years and older, for conditions listed in metric definition. Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the PQIs are counted only once in the composite numerator.	Population ages 18 years and older in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.	AHRQ		Annually	
Model Performance – Access to Care	Pediatric Quality Overall Composite	Pediatric Quality Indicators (PDI) overall composite per 100,000 population, ages 6 to 17 years. Includes admissions for one of the following conditions: asthma, diabetes with short-term complications, gastroenteritis, or urinary tract infection.	Discharges, for patients ages 6 to 17 years, for conditions listed in metric definition. Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the PQIs are counted only once in the composite numerator.	Population ages 6 to 17 years in metropolitan area† or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.	AHRQ		Annually	
Model Performance – Access to Care	Prevention Quality Overall Composite	Combines Chronic and Acute PQIs. Prevention Quality Indicators (PQI) overall composite per 100,000 population, ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with	Discharges, for patients ages 18 years and older, for conditions listed in metric definition. Discharges that meet the inclusion and exclusion rules for the numerator in more than one of the PQIs are	Population ages 18 years and older in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not	AHRQ		Annually	

		long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection.	counted only once in the composite numerator.	the metropolitan area or county of the hospital where the discharge occurred.				

Population health

Metric Area	Clinical Quality Measure Alignment (NQF)	Indicator	Numerator	Denominator	Primary Data Source	Reporting Frequency	Alignment with Other CMS Programs	Most Recent Rate (Year)
Model Performance - Population Health	Hypertension (0018)	Awareness of high blood pressure among adults aged ≥18 years	Colorado residents aged ≥ 18 years who report ever having been told by a doctor, nurse, or other health professional that they have high blood pressure. Women who were told of high blood pressure only during pregnancy and those who were told they had borderline hypertension were not included.	Colorado residents aged ≥ 18 years (excluding those who refused to answer, had a missing answer, or answered "don't know/not sure").	BRFSS	Biennial (odd years) prevalence	CPCI; TCPI	25.3% (2014)
Model Performance - Population Health	Obesity (0421 & 0024)	Obesity	Colorado residents ages 6-14 with a body mass index (BMI) at or above the sex- and age-specific 95th percentile from the Centers for Disease Control (CDC) U.S. growth charts.†	Colorado residents aged 6-14 whose parents answered height, weight, sex and age questions within a plausible range according to CDC sex-and age specific ranges (excluding unknowns, refusals to provide weight or height, and exclusions listed below).	CHS	Annual Prevalence	CPCI; TCPI	12.8% (2014)

			Colorado students in grades 9-12 with a body mass index (BMI) at or above the sex- and age-specific 95th percentile from the CDC U.S. growth charts.	Colorado students in grades 9–12 who answer height, weight, sex and age questions within a plausible range according to CDC sex-and age specific ranges (excluding unknowns, refusals to provide weight or height and exclusions listed below).	HKC	Biennial (odd years) Prevalence	CPCI; TCPI; CO Winnable Battles	8.0% (2013)
			Colorado residents aged ≥18 years who have a body mass index (BMI) ≥30.0 kg/m² calculated from self-reported weight and height. Exclude the following: • Height: data from respondents measuring <3ft or ≥8 ft • Weight: data from respondents weighing <50 lbs. or ≥650 lbs. • BMI: data from respondents with BMI <12 kg/m2 or ≥100 kg/m2 • Pregnant women	Colorado residents aged ≥18 years for whom BMI can be calculated from their self-reported weight and height (excluding unknowns, refusals to provide weight or height and exclusions listed below).	BRFSS	Annual Prevalence	CPCI; TCPI; CO Winnable Battles	21.3% (2014)
Model Performance - Population Health	Breast Cancer Screening (0031) & Colorectal Screening (0034)	Proportion of older adults aged ≥65 years who are up to date on a core set of clinical preventive services by age and sex.	Women: Number of Colorado female residents aged ≥65 years reporting having received all of the following: an influenza vaccination in the past year; a pneumococcal vaccination (PPV) ever; either a fecal occult blood test (FOBT) within the past year, a sigmoidoscopy within the past 5 years and an FOBT within the past 3 years, or a colonoscopy within the previous 10 years; and a mammogram in the past 2 years. Men: Number of Colorado male residents aged ≥65 years reporting having received all of the following: an influenza vaccination in the past	Women: Number of Colorado female residents aged ≥65 years. Men: Number of Colorado male residents aged ≥65 years.	BRFSS	Annual prevalence	CPCI; TCPI	7.7% (2012)

			year; a PPV ever; and either an FOBT within the past year, a sigmoidoscopy within the past 5 years and an FOBT within the past 3 years, or a colonoscopy within the past 10 years.					
Model Performance - Population Health	Flu (0041)	Influenza vaccination among adults aged ≥18 years ¥	Colorado residents aged ≥18 years who report having received an influenza vaccination within the previous year.	Colorado residents aged ≥18 years who report having or not having an influenza vaccination within the previous year (excluding those who refused to answer, had a missing answer, or answered "don't know/ not sure").	BRFSS	Annual prevalence		44.0% (2013)
Model Performance - Population Health	Asthma (0036)	Asthma	Colorado residents ages 5-14 whose parent report that they have you ever been told by a doctor, nurse, or other health professional that their child had asthma.	Colorado residents ages 5-14 years whose parents report having or not having asthma diagnosis (excluding those who refused to answer, had a missing answer, or answered "don't know/not sure").	CHS	Annual prevalence	CPCI; TCPI	17.5% (2014)
			Colorado students in grades 9-12 who report ever being told by a doctor, nurse, or other health professional that they had asthma.	Colorado students in grades 9-12 who report having or not having asthma diagnosis (excluding those who refused to answer, had a missing answer, or answered "don't know/not sure").	HKC	Prevalence	CPCI; TCPI	20.9% (2013)
			Colorado residents aged ≥18 years who report ever being told by a doctor, nurse, or other health professional that they had asthma	Colorado residents aged ≥18 years who report having or not having asthma diagnosis (excluding those who refused to answer, had a missing answer, or answered "don't know/not sure").	BRFSS	Annual prevalence	CPCI; TCPI	12.2% (2014)
Model Performance - Population Health	Diabetes: comprehensive care (0059)	Prevalence of diagnosed diabetes among	Colorado residents aged ≥18 years who report ever been told by a doctor or other health professional that they have diabetes other than diabetes during pregnancy.	Colorado residents aged ≥18 years who report or do not report ever been told by a doctor or other health professional that they have diabetes (excluding those who refused to answer, had a missing	BRFSS	Annual prevalence	CPCI; TCPI	7.3% (2014)

		adults aged ≥18 years		answer, or answered “don‘t know/not sure”).				
Model Performance - Population Health	Diabetes: blood pressure management (0061)	Prevalence of self-reported high blood pressure among adults aged ≥18 years with diagnosed diabetes	Colorado residents aged ≥18 years ever told by a doctor or other health professional that they have diabetes (excluding women who were told only when pregnant, refusals and unknowns) who report having ever been told by a doctor, nurse, or other health professional that they had high blood pressure (excluding during pregnancy).	Colorado residents aged ≥18 years ever told by a doctor or other health professional that they have diabetes (excluding women who were told only when pregnant, refusals and unknowns).	BRFSS	Biannual (odd years) prevalence	CPCI; TCPI	57.9% (2013)
Model Performance - Population Health	Ischemic Vascular Disease (clinical quality measure TBD)	Mortality from total cardiovascular diseases	Deaths with *International Classification of Diseases, 10th Revision* codes I00-I99 as the underlying cause of death among Colorado residents during a calendar year.	Mid-year Colorado resident population for the same calendar year.	Vital Statistics	Annual Mortality	CPCI	171.9 per 100, 000 (2014)
		Mortality from coronary heart disease	Deaths with *International Classification of Diseases, 10th Revision* (ICD-10) codes I20–I25 as the underlying cause of death among Colorado residents during a calendar year.	Mid-year Colorado resident population for the same calendar year.	Vital Statistics	Annual Mortality	CPCI	70.1 per 100, 000 (2014)
		Mortality from heart failure	Deaths with *International Classification of Diseases, 10th Revision* code I50 as the underlying or contributing (any mentioned) cause of death among Colorado residents during a calendar year.	Mid-year Colorado resident population for the same calendar year.	Vital Statistics	Annual Mortality	CPCI	13.7 per 100, 000 (2014)
		Mortality from cerebrovascular disease (stroke)	Deaths with *International Classification of Diseases, 10th Revision* codes I60-I69 as the underlying cause of death among Colorado residents during a calendar year.	Mid-year Colorado resident population for the same calendar year.	Vital Statistics	Annual Mortality	CPCI	31.6 per 100, 000 (2014)

		Hospitalizations from cerebrovascular disease	Hospitalizations with principal diagnosis *International Classification of Diseases, Ninth Revision, Clinical Modification* codes 430-434 and 436-438 among residents during a calendar year	Mid-year resident population for the same calendar year.	Colorado Hospital Associ-ation (CHA) Hospital-izations Data	Annual Incidence	CPCI	1.11 per 1,000 (2014) ∞
		Hospitalizations from myocardial infarction	Hospitalizations with principal diagnosis of *International Classification of Diseases, Ninth Revision, Clinical Modification* code 410 among residents during a calendar year.	Mid-year resident population for the same calendar year.	CHA Hospital-izations Data	Annual Incidence	CPCI	1.40 per 1,000 (2014) ∞
Model Performance - Population Health	Safety - Falls prevention (0101)	Fall within past year among older adults	Respondents aged ≥65 who reported falling and that the falls resulted in an injury	All Colorado residents aged ≥65	BRFSS	Prevalence Not Available Annually	CPCI; CO Winnable Battles	27.1% (2014)
		Fall hospitalization rates among older adults	Hospitalizations with principal diagnosis of *International Classification of Diseases, Ninth Revision, Clinical Modification* codes 880-888 among residents aged ≥65 during a calendar year.	Mid-year resident population aged ≥65 for the same calendar year.	CHA Hospital-izations Data	Annual Incidence	CPCI; CO Winnable Battles	1241.3 (2014)
		Fall death rates among older adults	Deaths with *International Classification of Diseases, 10th Revision* codes w00-w19 as the underlying cause of death among residents aged ≥65 during a calendar year.	Mid-year resident population aged ≥65 for the same calendar year.	Vital Statistics	Annual Mortality	CPCI; CO Winnable Battles	99.4 per 100, 000 (2014)
Model Performance - Population Health	Depression Screening for patients ≥ 12 Follow-Up treatment plan reached (NQF 0418 Adolescents & Adults)	Adults who are currently depressed	Colorado residents aged ≥18 years whose answers to PHQ-8 scale indicated that they were currently depressed.	Colorado residents aged ≥18 years (excluding those who refused to answer, had a missing answer, or answered “don‘t know/not sure”).	BRFSS	Biannual prevalence	CPCI; TCPI; CO Winnable Battles	6.9% (2014)
		Men who are currently depressed	Colorado male residents aged ≥18 years whose answers to PHQ-8 scale indicated that he was currently depressed.	Colorado male residents aged ≥18 years (excluding those who refused to answer, had a missing answer, or answered “don‘t know/not sure”).	BRFSS	Biannual prevalence	CPCI; TCPI; CO Winnable Battles	5.7% (2014)

		Adults with mental disability days	Sum of the number of days in the past 30 days for which Colorado residents aged ≥18 years report that their physical health and/or mental health (including stress, depression, and problems with emotions) was not good.	Total number of Colorado residents aged ≥18 years who report 0 days in the past 30 days for which their mental health was not good (excluding those who refused to answer, had a missing answer, or answered "don't know/ not sure").	BRFSS	Annual prevalence	CPCI; TCPI; CO Winnable Battles	35.0% (2014)
		Adults being treated for mental health	Colorado residents who reported taking medication or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem	Colorado residents aged ≥18 years (excluding those who refused to answer, had a missing answer, or answered "don't know/not sure").	BRFSS	Prevalence	CPCI; TCPI; CO Winnable Battles	12.1% (2013)
		Depressive symptoms among high school (HS) students	Colorado students in grades 9-12 who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months	Colorado students grades 9-12 (excluding those who refused to answer, had a missing answer, or answered "don't know/not sure").	HKC	Biannual (odd years) prevalence	CPCI; TCPI; CO Winnable Battles	24.3% (2013)
		Suicide attempts among HS students	Colorado students in grades 9-12 who made a suicide attempt during the past 12 months that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse	Colorado students grades 9-12 (excluding those who refused to answer, had a missing answer, or answered "don't know/not sure").	HKC	Biannual (odd years) prevalence	CPCI; TCPI; CO Winnable Battles	2.3% (2013)
		Suicide death rate	Deaths with *International Classification of Diseases, 9th Revision* codes 950-959 as the underlying cause of death among Colorado residents during a calendar year.	Mid-year Colorado resident population for the same calendar year.	Vital Statistics	Annual Prevalence	CPCI; TCPI; CO Winnable Battles	19.8 per 100, 000 (2014)

Model Performance - Population Health	At least one depression screening during well child visit (NQF 1401 Maternal Depression Screening)	Maternal depression symptoms	Colorado residents aged 18-44 who reported that they felt down, depressed, or hopeless often or always after their most recent live birth.	Colorado residents aged 18-44 who reported that they felt down, depressed, or hopeless never, rarely, sometimes, often, or always after delivery of their most recent live birth (excluding those who refused to answer, had a missing answer, or answered "don't know/not sure").	PRAMS	Annual Prevalence	CPCI; TCPI; CO Winnable Battles	11.0% (2013)
		Prenatal care counseling about maternal depression	Colorado residents aged 18-44 who had a live birth who reported that a doctor, nurse or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery	Colorado residents aged 18-44 who had a live birth (excluding those who refused to answer, had a missing answer, or answered "don't know/ not sure").	PRAMS	Annual Prevalence	CPCI; TCPI; CO Winnable Battles	78% (2013)
Model Performance - Population Health	Anxiety - Patients aged 18-75 annually screened with GAD-7	Anxiety disorders among adults	Colorado residents aged ≥18 years who have ever told by a doctor or other health professional report that they have an anxiety disorder	Colorado residents aged ≥18 years (excluding those who refused to answer, had a missing answer, or answered "don't know/not sure").	BRFSS	Biannual Prevalence	CO Winnable Battles	15.1% (2014)
		Adults being treated for mental health	Colorado residents aged ≥18 years who reported taking medication or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem	Colorado residents aged ≥18 years (excluding those who refused to answer, had a missing answer, or answered "don't know/not sure").	BRFSS	Prevalence	CO Winnable Battles	12.1% (2013)
Model Performance - Population Health	SUDs - Patients 18-75 annually screened for tobacco use, unhealthy alcohol use, nonmedical prescription drug	Heavy Alcohol Consumption	Colorado residents aged ≥21 years who report imbibing over the dietary guidelines for moderate drinking (males and females aged 21 [i.e. legal drinking age]+ and females who are not pregnant).	Adults aged ≥21 years who report a specific number, including zero, for the number of weekly drinks (excluding those who refused to answer, had a missing answer, or answered "don't know/not sure"), excluding pregnant women.	BRFSS	Annual Prevalence	CO Winnable Battles	6.5% (2014)

	use, and illicit drug use (NQF 2957)	Binge Drinking Summary Measure	Colorado residents aged ≥18 years who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.	Colorado residents aged ≥18 years who report having a specific number, including zero, of drinks on an occasion in the past 30 days (excluding those who refused to answer, had a missing answer, or answered “don‘t know/not sure”).	BRFSS	Annual Prevalence	CO Winnable Battles	17.5% (2014)
		Self-reported, non-medical opioid use	Respondents aged ≥ 12 years who reported ever having used prescription pain relievers without a prescription, using in greater amounts, more often, or longer than were prescribed, or using it in any other way a doctor did not direct.	Colorado residents aged ≥12 years (excluding those who refused to answer, had a missing answer, or answered “don‘t know/not sure”).	NSDUH	Annual Prevalence	CO Winnable Battles	Waiting on new prevalence estimate from the Substance Abuse and Mental Health Services Administration (SAMHSA)‡
		Risky prescription opioid dosage	Patients receiving prescriptions for > 120 milligrams of morphine equivalence daily per quarter, averaged per year.	Patients receiving prescriptions in Colorado.	PDMP	Quarterly Prevalence	CO Winnable Battles	5.32% (2014)
		Prescription-drug overdose deaths	Deaths with International Classification of Diseases, 10th Revision codes X40-X44; X60-X64;	Mid-year resident population aged ≥ 15 for the same calendar year.	Vital Statistics	Annual Prevalence	CO Winnable Battles	11.0 per 100,

			X85; & Y10-Y14 as the underlying cause of death among residents aged ≥ 15 during a calendar year.					000 (2014)
		Current smoking among adults aged ≥18 years	Colorado residents aged ≥18 years who report having smoked ≥100 cigarettes in their lifetime and currently smoke every day or some days.	Colorado residents aged ≥18 years who reported information about cigarette smoking (excluding those who refused to answer, had a missing answer, or answered "don't know/not sure").	BRFSS	Annual prevalence	CO Winnable Battles	15.7% (2014)
		Smokers who attempt to quit	Colorado residents aged ≥18 years who report having smoked ≥100 cigarettes in their lifetime and currently smoke every day or some days and who report attempting to quit smoking in the past year.	Colorado residents aged ≥18 years who report having smoked ≥100 cigarettes in their lifetime and currently smoke every day or some days.	BRFSS	Annual Prevalence	CO Winnable Battles	63.1% (2014)
Model Performance - Population Health	Developmental Screening (NQF 0418)	Developmental screening for children	Children whose parent was asked by a health care provider to fill out a questionnaire about development, communication, or social behavior of their child ages 1 through 5	Colorado parents	CHS	Prevalence	CO Winnable Battles	23.7% (2013)

Master Timeline for SIM Model

Governance, Management and Decision Making ***Goal: Oversee, coordinate and ensure success of all SIM project deliverables***	**2016**				**2017**				**2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Convene Advisory Board Meetings	x	x	x	x	x	x	x	x	x	x	x	x
Convene Steering Committee Meetings	x	x	x	x	x	x	x	x	x	x	x	x
Convene SIM Workgroup Meetings	x	x	x	x	x	x	x	x	x	x	x	x
Oversee execution of deliverables for all SIM contracts	x	x	x	x	x	x	x	x	x	x	x	x
Monitor implementation of SIM model components	x	x	x	x	x	x	x	x	x	x	x	x
Recruit/retain SIM Office staff	x	x	x	x	x	x	x	x	x	x	x	x
Ongoing outreach/engagement with public/private partners and stakeholders	x	x	x	x	x	x	x	x	x	x	x	x
Stakeholder Engagement ***Goal: Ensure the active engagement of all stakeholders, including but not limited to payers, providers and key contractors***	**2016**				**2017**				**2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Quarterly SIM Newsletter	x	x	x	x	x	x	x	x	x	x	x	x
SIM Charter outlining stakeholder workgroup objectives posted to SIM website	x											
SIM to co-host Medical Home Community Forum	x	x	x	x	x	x	x	x				
Articulation of SIM Strategies	x											
SIM Outreach Tour				x				x				x
Identification of strategies to Directly Engage Consumers (e.g. during SIM Outreach Tour, consumer section of SIM website, via existing consumer groups etc.)	x	x										
Convening of Annual SIM Conference				x				x				x
SIM Consumer Engagement and Public Comment Logs	x	x	x	x	x	x	x	x	x	x	x	x

Population Health Plan ***Goal: To develop and execute on a plan for improving population health with Governor's Office, key state agencies and stakeholders***	**2016**				**2017**				**2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Regional Health Connectors (RHCs)												
First RHC Cohort Selected	x											
Second RHC Cohort Selected		x										
Third RHC Cohort Selected			x									
RHC Workplan Annual Workplan	x				x				x			
RHC Quarterly Meetings	x	x	x	x	x	x	x	x	x	x	x	x
RHC Quarterly Reports	x	x	x	x	x	x	x	x	x	x	x	x
RHC Final Report and Sustainability Plan												x
Grants to Local Public Health Agencies (LPHAs)												
Announcement of selected LPHAs	x											
Awards made to selected LPHAs	x											
LPHAs implement award-funded activities		x	x	x	x	x	x	x	x	x	x	x
Grants to Population Health Collaboratives												
Announcement of selected First Cohort Collaboratives	x											
Awards made to selected First Cohort Collaboratives	x											
Collaboratives implement award-funded activities		x	x	x	x	x	x	x	x	x	x	x
RFA Released for Second Cohort Collaboratives			x									
Announcement of Second Cohort Collaboratives					x							
Awards made to selected Second Cohort Collaboratives					x							
Second Cohort Collaboratives implement funded-activities						x	x	x	x	x	x	x
Provider Education												
CDPHE Provider Education Plan reviewed and finalized	x											
Launch of Obesity and Depression, Depression in Men, and Pregnancy-Related Depression modules	x											
Dissemination of online training modules		x	x	x	x	x	x	x	x	x	x	x

Provide information and resources about pregnancy and substance use to all providers involved in the SIM initiative		x										
Distribute state guidelines for psychotropic medications for children			x									
Develop an online substance use disorder course for primary care providers					x							
Enhance and expand the work of SBIRT					x							
Develop an education course to address trauma and trauma related issues							x					
Develop on-line course for senior behavioral health issues and intervention strategies							x					
Develop a voluntary certificate for Integrated Behavioral Health Staff												x
Develop a set of Best Practice Guidelines for Behavioral Health staff working in Health Settings											x	

Practice Transformation Plan ***Goal: Provide intensive support to practices to integrate behavioral health and primary care***	**2016**				**2017**				**2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Practice Transformation Organizations (PTOs)												
Onboarding and training for PTOs	x											
PTOs matched to primary care practices	x	x			x	x			x	x		
PTOs conduct readiness assessments using Shared Practice Learning Improvement Tool (SPLIT)		x	x		x	x			x	x		
PTOs deploy practice facilitators and Clinical Health Information Technology Advisors (CHITAs) to support practices		x	x	x	x	x	x	x	x	x	x	x
Practice Transformation Primary Care Cohorts												
Update Project Management/Operational Plan	x				x				x			
Practice Cohort 1 practices selected and onboarded	x	x										
SIM Implementation Guide and Toolboxes available to practices		x										

E-Learning courses disseminated (modules to be rolled out incrementally)		x	x	x	x	x	x	x	x	x	x	x
Practices convened for Learning Collaboratives		x		x		x		x		x		x
Clinical Quality Measures reporting		x	x	x	x	x	x	x	x	x	x	x
Conduct Open Door Forum/Webinar for Cohort 2			x				x				x	
RFA for Practice Cohort 2			x									
Practice Cohort 2 selection				x								
Practice Cohort 2 begins					x							
Conduct Open Door Forum/Webinar for Cohort 3			x				x					
RFA for Practice Cohort 3							x					
Practice Cohort 3 selection								x				
Practice Cohort 3 begins									x			
Practice Transformation Fund for Primary Care Cohorts												
RFA - practices for Practice Transformation Funds		x			x				x			
Funds distributed to awardees			x			x				x		
Bi-Directional Health Homes												
Health Home Pilot Sites begin	x											
Health Homes Peer-Supported Learning Groups	x	x	x	x	x	x	x	x	x	x	x	x
Health homes patient enrollment & initial primary care visits			x	x	x							
Patient-specific and population-based data collection underway			x	x	x							
Health Home sites fully operational and the model in full implementation					x	x	x	x	x	x	x	x
Health Home Clinical Quality Metrics reporting					x	x	x	x	x	x	x	x
Data analytics used to substantiate evidence base for bi-directional integration						x	x	x	x	x	x	x
Health Home sites develop and submit final reports on all defined performance metrics, outcomes, cost savings, and lessons learned										x	x	x

Health Homes pilot final report detailing aggregate data on health outcomes, financial savings, and all other performance metrics									x	x	x
Payment Reform ***Goal: By 2019, payers serving a majority of Coloradans will reimburse practices for integrated physical health and behavioral health services in shared risk and savings programs***	**2016**				**2017**				**2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Payers sign Memorandum of Understanding with SIM Office	x											
Payers identify SIM practices they will support with alternative payment models in conjunction with SIM Office selection of initial cohort	x											
Payers submit description of payment models that will be used to support SIM practices to the SIM Office as an Addendum to MOU	x											
Engage in ongoing conversations with CMS regarding Medicare participation in SIM payment models	x	x										
Payers determine: 1) whether they can report attributed lives in practice based on 4 LAN framework categories; 2) whether they can report attributed lives in non-SIM participating practices - July 1, 2016		x										
Payers report on the following, two times a year: attributed lives in SIM; practices in SIM				x		x		x		x		x
Determine expansion of RISE and Stratus tool licenses to practices participating in first SIM cohort	x											
Continue outreach/engagement with self-insured employers, VA, and TRICARE	x	x	x	x	x	x	x	x				
Work with HCPF to align Medicaid payment approaches with SIM initiatives/objectives; explore need for additional federal authorities as part of ACC Phase II, including Section 2703 Home Health or other waivers	x	x	x	x	x	x	x	x	x	x	x	x

Utilize state employee health to expand/drive adoption of integrated care delivery and value-based payments	x	x			x	x			x	x		
Work with payers and the University of Colorado to establish processes, criteria for the selection of practices for SIM cohorts 2 and 3			x	x			x	x				
Leveraging Regulatory Authority ***Goal: Utilize a range of legislative, regulatory, and policy levers to advance SIM goals and objectives and the achievement of the Triple Aim***	**2016**				**2017**				**2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Monitor legislative activities at state and federal level to identify risks/opportunities related to SIM initiatives	x	x	x	x	x	x	x	x	x	x	x	x
Work with state agencies and other organizations to coordinate/align legislative agendas	x	x	x	x	x	x	x	x	x	x	x	x
Work with state agencies to consolidate/streamline the fragmented oversight of physical, mental, and substance use providers and programs	x	x	x	x								
Identify non-rule barriers (differing payment structures/philosophies, disease-based model of care, operational barriers) to integrated care and recommend policy solutions	x	x	x	x	x							
Clarify state and federal rules regarding information sharing between providers, specifically related to patient privacy and confidentiality and consent	x	x										
Work with state and local public health agencies and other organizations to jointly advance regulatory issues that improve population health	x	x	x	x	x	x	x	x	x	x	x	x
Utilize policy levers to remove barriers and advance opportunities for integrated care delivery systems	x	x	x	x	x	x	x	x	x	x	x	x
Utilize policy levers to remove barriers and advance opportunities for alternative payment models	x	x	x	x	x	x	x	x	x	x	x	x

Leverage state resources and capacity as a payer and regulator to advance SIM goals and objectives (state employee health plan, QHP certification requirements)	x	x			x	x			x	x		
Evaluate levers advancing health information sharing (i.e., investments in expanding health information data infrastructure, subscription subsidies to health technology platforms, improving a patient centric approach to data sharing among care settings, public and private)	x	x	x	x	x	x	x	x	x	x	x	x
Monitor federal health IT policy, programs, and standards recommendations and disseminate statewide	x	x	x	x	x	x	x	x	x	x	x	x
Evaluate telehealth regulations identifying potential barriers for widespread adoption - reimbursement, prescribing, and home monitoring	x	x	x	x								
Address scope of practice laws, credentialing and/or licensing to accommodate changing workforce	x	x	x	x								
Explore legislative/regulatory actions to strengthen Colorado's workforce pipeline			x	x	x	x						
Assess and recommend administrative policy changes that streamline and reduce unnecessary paperwork and costs within the health care system	x	x	x	x	x	x	x	x	x	x	x	x

Workforce Development Monitoring ***Goal: Build a workforce that is sufficient in capacity, training, efficiency, and effectiveness to provide 80% of all Coloradans with access to comprehensive primary care that integrates physical and behavioral health by 2019***	**2016**				**2017**				**2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Perform environmental scan of practices, training and education programs, and workforce partners throughout the state to understand their respective activities for integrated care and create map of these efforts	x	x	x	x	x	x	x	x	x	x		
Generate policy recommendations as they relate to health workforce innovation throughout the state	x	x	x	x	x	x	x	x	x	x	x	x

Report out on Workforce Workgroup progress at the SIM annual conference				x				x				x

Health Information Technology ***Goal: Develop a seamless IT infrastructure and data hub that supports the needs of communities in direct clinical care and population health***	**2016**				**2017**				**2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Telehealth												
Expand broadband statewide	x	x	x	x	x	x	x	x	x	x	x	
Develop statewide strategy	x	x	x	x								
Implement telehealth strategy to expand broadband Statewide				x	x	x	x	x	x	x	x	x
Shared Practice Learning and Improvement Tool												
Training for Practice Transformation Organizations on use of SPLIT	x	x										
Initial use of SPLIT with first cohort practices		x										
Enhancement of SPLIT		x	x	x	x							
Continued use of SPLIT to assess practice progress and establish readiness of practices in subsequent cohorts			x	x	x	x	x	x	x	x	x	x
Quality Measurement Tool Development (QMRT)												
Vendor selected for design of short-term QMRT	x											
Short Term Solution operational		x										
Benchmark report to First Cohort Practices			x									
Quarterly collection of Clinic Quality Measures via QMRT		x	x	x								
SIM All-Stars												
Characteristics Identified				x								
Resources identified					x							
Cohort #1 All-Star Practices chosen					x							
Cohort #2 All-Star Practices chosen							x					
Cohort #3 All-Star Practices chosen										x		
All-Star Case Studies Developed						x	x	x	x	x	x	

All-Stars Honored and Publicized											x	
Data Acquisition and Aggregation with QMRT+ (Central Data Hub)												
Infrastructure Design Recommendation	x											
RFP process for development of QMRT+	x	x	x	x								
QMRT Design and Implementation					x	x						
Quarterly collection of Clinical Quality Measures via QMRT+						x	x	x	x	x	x	x

Program Monitoring and Reporting ***Goal: Develop both process and outcomes measures to track progress toward the Triple Aim***	**2016**				**2017**				**2018**			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
External Evaluation Vendor Contracted	x											
Initial work plan	x											
Revised evaluation framework	x											
Revised logic model	x											
Revised methodology	x											
Annual Data Analysis Plan	x				x				x			
Initial central repository of measures	x											
Plan for capturing baseline data	x											
Initial establishment of baseline	x											
Quarterly report		x	x	x		x	x	x		x	x	x
Preliminary annual report					x				x			x
Final annual report					x				x			x
Draft sustainability plan					x							
Final sustainability plan												x
APCD data pull	x	x	x	x	x	x	x	x	x	x	x	x
Attribution strategy identified	x											
Clinical quality measure reporting	x	x	x	x	x	x	x	x	x	x	x	x
Cost and utilization reporting	x	x	x	x	x	x	x	x	x	x	x	x

Access to care reporting				x				x				x
Population health reporting				x				x				x
Payer/payment model participation reporting		x		x		x		x		x		x
Model participation reporting (practice transformation, population health, HIT)	x	x	x	x	x	x	x	x	x	x	x	x

Budget Summary

Budget Categories	Sub-categories	Vendor	Budgets Year 2
SIM Office			$ 1,551,437
Population Health	Regional Population	CDPHE	$ 2,199,803
	Population Health Training	DHS	$ 248,406
TOTAL Population Health			$ 2,448,209
Practice Transformation	Cohort Practice Facilitation	UCD	$ 3,169,600
	Practice Participation Grants	HCPF	$ 250,000
	Small Grants to Practices	HCPF	$ 1,043,109
	Bi-Directional Health Homes	CBHC	$ 1,355,390
TOTAL Practice Transformation			$ 5,818,098
TOTAL Regional Health Connectors		CHI	$ 1,271,395
HIT	HIT PM and Administration	TBD	$ 561,598
	Practice Assessment Tool	UCD	$ 223,125
	Data Quality (CQMs)	TBD	$ 621,894
	Data Warehousing	TBD	$ 713,033
	User Interfaces	TBD	$ 255,000
	Data Acquisition	TBD	$ 501,975
TOTAL HIT			$ 2,876,625
Telehealth	Broadband	CTN	$ 246,479
	TRC Strategic Plan	TBD	$ 200,000
	Telehealth Resource Center	TBD	$ 672,160
TOTAL Telehealth			$ 1,118,639
Data	APCD	CIVHC	$ 687,900
	Actuary	Milliman	$ 500,000
TOTAL Data			$ 1,187,900
TOTAL Evaluation		TBD	$ 1,227,606
GRAND TOTAL			$ 17,499,910

Governance, Management and Decision Making

Colorado tapped a wide range of experts and innovators from throughout the state to develop its application for the SIM award and craft the SHIP. 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. The SIM Office has continued to engage stakeholders throughout the year one planning and implementation process via a number of paths, including a 13-member Advisory Board, an 18-member Steering Committee to provide ongoing advice and feedback, and eight targeted stakeholder working groups centered on payment reform, practice transformation, population health, HIT, policy, consumer engagement, workforce and evaluation tracks. A communications plan updated the interested public through a website and social media postings, and 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 tradition of collaboration. In total, nearly 200 stakeholders regularly participate in Colorado's SIM planning and implementation process.

The Colorado SIM Office, established by Executive Order in March 2015, is leveraging this robust stakeholder process to achieve our goal of improving the health of Coloradans by providing access to integrated primary care and behavioral health services in coordinated community systems, with value-based payment structures, for 80 percent of state residents by 2019. In developing the governance and management structure, the SIM Office has incorporated and built upon the leadership, relationships, cooperation, and momentum generated through the early planning work. The resulting framework capitalizes on a set of assets, including strong leadership and support from the State's Executive Office, inter-agency and public-private collaboration, and the active engagement of stakeholders from across the state, representing the full spectrum of the health community.

Governor's Office Engagement

Colorado SIM benefits from a history of meaningful stakeholder involvement in health care transformation that has spanned the terms of the last three governors. In 2006, former Governor Bill Owens, a Republican, signed Senate Bill 06-208, creating the Colorado Blue Ribbon Commission on Health Care Reform (Blue Ribbon Commission). The 27-member Commission was charged with "studying and establishing health care reform models to expand health care health care coverage and decrease health care costs for Colorado residents," and authorized to "examine options for expanding affordable health coverage for all Colorado residents in both the public and private sector markets, with

special attention given to the uninsured, the underinsured, and those at risk of financial hardship due to medical expenses."[1]

Governor Owens' successor, former Governor Bill Ritter, a Democrat, embraced the Commission and worked closely with its members, including health care consumers, providers, payers, and policymakers, to examine several proposals. In 2008, the Commission submitted 32 recommendations to the General Assembly, many of which have subsequently been enacted into law. In addressing issues such as affordable care, improved access and better health outcomes, the Commission served as an early precursor to the Triple Aim and the federal Patient Protection and Affordable Care Act.

Current Governor John Hickenlooper has taken an active leadership role in pursuing initiatives that promote and advance the health of state residents. In 2012, Governor Hickenlooper created the Office of Community Living to redesign all aspects of the Long Term Support Services (LTSS) delivery system and the Community Living Advisory Group (CLAG) to provide leadership and a forum to develop these activities and create efficient, whole person, community-based care. Prior to the 2013 legislative session, the Governor introduced a plan to redesign and strengthen Colorado's system for caring for the mentally ill, which resulted in the creation of the first statewide mental health crisis hotline. In addition, Governor Hickenlooper recently signed an Executive Order to establish an Office of eHealth Innovation with the goal of creating an overarching governance structure for information technology investments in the state.

State of Health

In April 2013, Governor Hickenlooper released *The State of Health: Colorado's Commitment to Become the Healthiest State*, a report that outlined a vision for building a comprehensive, person-centered statewide system that delivers the best care at the best value to help Coloradans achieve the best health. The plan calls upon public and private organizations, as well as Colorado citizens, to work together to specific targets – measured by 21 metrics across 18 initiatives – across four strategic focus areas: prevention and wellness; coverage, access, and capacity; system integration and quality; and value and sustainability. The State of Health agenda builds off previous state investments and existing programs and initiatives to improve health, including Colorado's Winnable Battles. The Winnable Battles are ten key public health and environmental issues, which represent Colorado's greatest opportunities to ensure the health of citizens and to improve and protect the environment. They were

[1] Senate Bill 06-208

chosen with consideration of national and local goals, including CDC's Winnable Battles, the Seven Priorities for the Environmental Protection Agency's (EPA's) Future, and local public health and environmental priorities.[2] Colorado SIM has incorporated several of the measures used to evaluate progress on Winnable Battle into the SIM dataset, to continue the alignment of national, state, and local efforts. For a complete discussion of the Winnable Battles framework see the ***Plan for Improving Population Health*** section of the Operational Plan.

Colorado's State Health Innovation Plan (SHIP)

Colorado was awarded a SIM pre-testing cooperative agreement that was used to develop the SHIP, an extension of several of the objectives, goals, and metrics outlined in the *State of Health*. The plan includes four key dimensions, which have the potential to impact and be impacted by the integration of physical and behavioral health:

- Promoting prevention and wellness – integrated primary care will facilitate better health behaviors by providing individuals with the care and resources they need to reduce substance dependence and maintain or achieve a healthy weight, among other behaviors;
- Expanding coverage, access, and capacity – by committing to integrated primary care, SIM is also committing to building a healthcare workforce capable of achieving our goal and ensuring access to integrated care;
- Improving health system integration and quality – building integrated primary care atop our strong foundation of primary care medical homes and other system-level innovations will support its long-term sustainability; and
- Enhancing value and strengthening sustainability – integrated care will help us achieve our Triple Aim goals.

The *State of Health* and the SHIP are complementary declarations of the Hickenlooper administration's commitment to making Colorado the healthiest state in the nation. As such, the SHIP will be owned and managed by the administration, through the SIM Office, with continued input from stakeholders and partners. In developing the SHIP, stakeholders made careful choices about how to balance competing priorities in order to best accomplish its charge. This balancing of priorities will continue to be important as the Colorado SIM Office moves forward in advancing health care innovation in the state.

[2] "Colorado's 10 Winnable Battles," accessed at https://www.colorado.gov/pacific/sites/default/files/CHAPS1_PhaseI-Winnable-Battles-fact-sheet.pdf

The Governor's Office has played a leading role in the state's SIM initiative from its inception, through the planning award, to the present. Members of the Governor's staff hold several positions within the SIM governance structure, and are actively engaged in planning and implementation activities. The Governor's Senior Health Advisor currently serves as the Chair of the Consumer Engagement Workgroup, sits on the Steering Committee, acts as a liaison between the Governor's Office and SIM, and provides guidance and support to the SIM Policy Analyst. The former State HIT Coordinator served as the Chair of the HIT Workgroup and played a key role in the development of the SIM HIT proposal. While this position is currently unfilled, the SIM Office will continue to coordinate HIT activities with the Governor's office through the Director of the newly created Office of eHealth Innovation. The Colorado SIM Director was appointed by the Governor and is based out of the Governor's Office. The SIM Director participates in Cabinet and other executive-level meetings to coordinate SIM activities with the Administration's other health care initiatives.

The Governor also appoints members of the SIM Advisory Board, which provides "advice, oversight, and guidance over the operation of the SIM Office and the management of grant funds… [and] recommendations about how to better integrate behavioral and physical health in Colorado."[3] Four of the thirteen seats[4] are reserved for members of the Governor's cabinet – the Executive Director of CDHS, the Executive Director of CDPHE, the Executive Director of the Department of CDHCPF, and the Commissioner of Insurance.

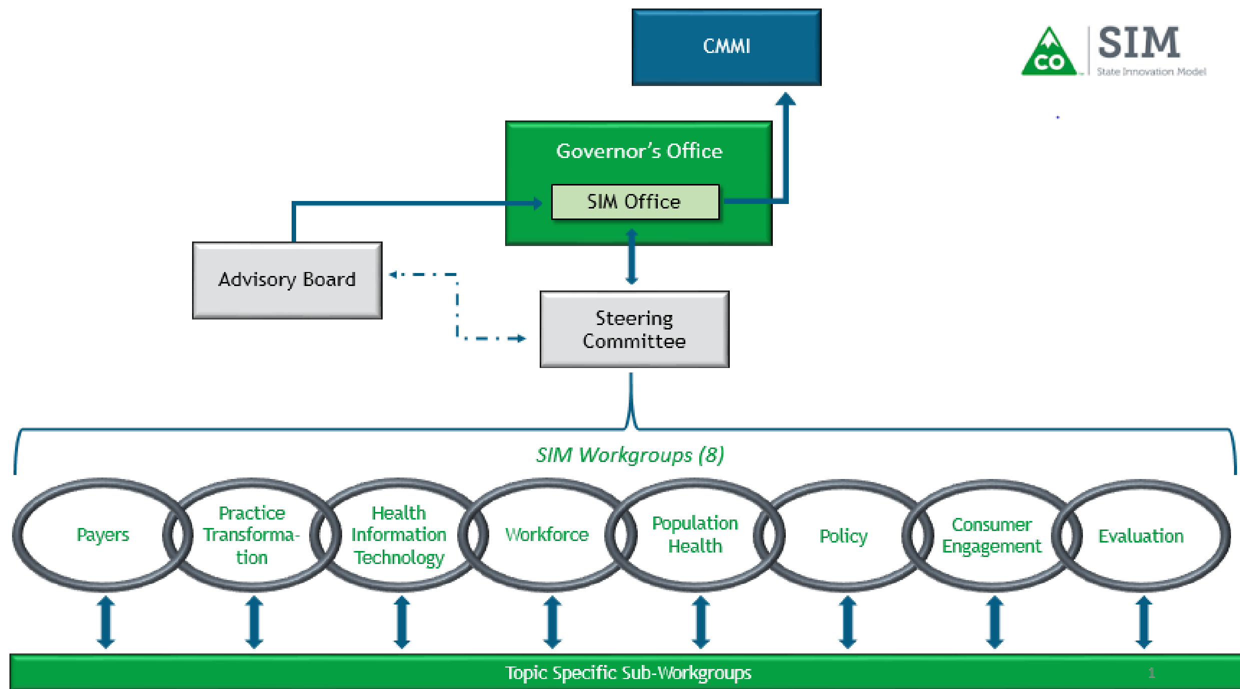
The multiple points of intersection between SIM and the Governor's Office ensure that the Governor maintains a direct line of contact, communication, and input into the initiative. The SIM Office's placement within the Governor's Office makes the initiative a natural forum for bringing state agencies and other stakeholders together to reach consensus and alignment around the state's health care priorities and overall goals and objectives.

Governance, Decision-Making and Stakeholder Representation

The SIM Office has adopted the following governance structure in order to best engage stakeholders, create avenues for the input of constituent groups who will implement the objectives of the program, and sustain a collaborative environment for this initiative:

[3] Executive Order B 2015-001.

[4] The Executive Order creating the Advisory Board (EO B 2015-001) was amended September 2015, to increase the number of members from 9 to 13.



SIM Office

The Office of the State Innovation Model (SIM), created by an executive order issued by Governor John Hickenlooper in March of 2015, is charged with overseeing Colorado's SIM initiative. The SIM Office is responsible for coordinating efforts with other state agencies, including CDHCPF, CDHS, CDPHE, the Colorado DORA, and The Department of Personnel and Administration (DPA); consulting with all relevant stakeholders, including representatives from the public, private, and nonprofit health care sectors; and facilitating and coordinating communications between state Departments, external stakeholders, and CMS.

The Colorado SIM Director was appointed by the Governor. Under the Director's leadership, the roles and responsibilities of the SIM Office include, but are not limited to:

- Coordinating with CMMI, the ONC and the Colorado Governor's Office to ensure all deliverables are met;
- Establishing standards for the SIM initiative;
- Executing and monitoring vendor contracts;
- Reporting on progress toward SIM goals and objectives;
- Ensuring all legal, regulatory, and administrative requirements are met; and

- Hiring or contracting staff, as needed, to fulfil the work outlined above.

The Colorado SIM Office oversees and supports the eight Workgroups, the Steering Committee, and the Advisory Board. Each workgroup has an assigned SIM Office staff member, who is responsible for: providing administrative support; answering SIM-related questions (e.g. project scope, program policies, and procedures); and facilitating communication and collaboration within and across workgroups. Collectively, the SIM Office staff works to ensure stakeholders engaged at each level of the governance structure have the resources and support needed to successfully meet their defined goals and objectives so that SIM initiatives can advance in a timely and efficient manner.

Workgroups

The eight SIM workgroups form the core of the SIM governance structure. Workgroup members were selected by the SIM Office through a competitive application process based on their subject-matter expertise. The SIM Office also sought to include representatives from a range of agencies and organizations – including educational institutions, consumer interest groups, philanthropic organizations, and the state legislature – that are not specifically focused on health, but address topics and issues that support the overall objectives of Colorado SIM. Each workgroup is led by two co-chairs and supported by a Program Manager from the SIM Office. (Please see the ***Stakeholder Engagement*** section of the Operational Plan for a detailed description of the Workgroups and their proposed Charters.)

Workgroups are responsible for broadly addressing the topics and issues associated with the particular component of the SIM project to which they have been assigned. Specific activities vary by group depending on the nature of the work and the associated deliverables (as applicable). All workgroup members were required to sign a Conflict of Interest form prior to participating in SIM, and were asked to recuse themselves from any workgroup discussions of Requests for Proposals (RFPs) or Requests for Applications (RFAs) that their respective organizations might bid on.

The workgroups are designed to provide a forum for stimulating ideas and discussions on how to advance Colorado SIM's goals and objectives. Workgroup members are tasked with identifying specific activities and/or action items, and making recommendations to the Steering Committee, Advisory Board, and ultimately the SIM Office. The SIM Office, as the sponsoring authority for the SIM initiative, holds ultimate decision-making authority, and is responsible for executing the recommendations made by any entity within the governance structure.

Steering Committee

The Steering Committee is made up of the co-chairs of each Workgroup, and is charged with:

- Reconciling issues and timeline dependencies brought forth by the SIM Office or workgroups;
- Establishing quality metrics for the SIM Initiative;
- Developing mitigation strategies for identified risks; and
- Ensuring that information is communicated across workgroups.

The SIM Steering Committee plays a critical role in coordinating the activities taking place in and across the SIM workgroups. The SIM Office made a conscious decision to create separate workgroups for each of the model's key components so that each group could focus on its particular area of expertise. Yet in so doing, the Office was acutely aware of the risk that each group could become isolated from the greater mission, raising the potential for duplication of efforts. The Steering Committee is tasked with identifying key dependencies between workgroups, and making sure they are moving forward in a coordinated and complementary fashion. In addition to discussions on cross-cutting issues, the Steering Committee also serves as a forum for addressing topics that cannot be resolved at the workgroup level. The Steering Committee can, in turn, refer difficult issues to the SIM Advisory Board for further guidance and recommendations.

SIM Advisory Board

The SIM Advisory Board provides oversight and guidance regarding the operation of the SIM Office and the management of SIM grant funds. Advisory Board members are appointed by the Governor to serve a four-year term. As initially laid out in the March 2015 Executive Order, the Board contained nine positions:

- The Director of the SIM, who will serve as the chairperson;
- A representative with experience or knowledge of behavioral health;
- A representative with experience or knowledge of primary health care;
- A representative with experience or knowledge of health care delivery;
- A representative with experience or knowledge of HIT;
- The Executive Director of CDHCPF, or his or her designee;
- The Executive Director of the Department of Human Services, or his or her designee;

- The Executive Director of the Department of Public Health and Environment, or his or her designee; and
- The Commissioner of Insurance, or his or her designee.

At the initial Advisory Board meeting on June 15, 2015, members discussed the composition of the Board, and heard public comments on whether it should be expanded to include additional representatives. Based on stakeholder feedback, the Governor's Office subsequently decided to add four additional positions, including: a representative of a statewide health insurance carrier; a representative of the statewide association of hospitals; and two representatives of consumer interests. In October 2015, the representative with knowledge of HIT resigned from the Board, leaving that appointment open as well.

The Office of Boards and Commissions accepted recommendations for the new members via a competitive application process, with consideration given to both geographic and racial diversity. Appointments to the new positions were announced by the Governor's Office on November 24, 2015, and new members were seated at the Advisory Board meeting on November 30, 2015.

A list of current Advisory Board members is attached as ***Appendix A.***

Programmatic, Financial and Communications Oversight

The CDHCPF is the designated fiscal agent for Colorado's SIM Model Test award. All vendor contracts to implement the SIM model must therefore go through CDHCPF's procurement process. All vendors must abide with terms and conditions contained in the SIM Notice of Award and the CMS Standard Grant/Cooperative Agreement, as well as any additional state agency requirements imposed by CDHCPF. Contracts for SIM-related work are primarily deliverable-based, and contain a detailed description of the vendor's responsibilities regarding the implementation of specific program components, the costs/finances associated with these activities, and the expectations regarding ongoing communication with the SIM Office. As the sponsoring authority for the SIM Initiative, the SIM Office maintains ultimate responsibility for the execution and monitoring of all vendor contracts, and ensuring the successful and timely completion of all project deliverables.

The SIM Office will coordinate implementation activities across key program areas with the various state agencies that are involved in the administration or regulation of Colorado's health care system, including CDHCPF, which administers Medicaid; CDPHE, which provides public health and environmental protection services; CDHS, which oversees behavioral health and social services; DORA, which oversees

the regulation of insurance and professional licensing; the Division of Insurance (DOI), which regulates the health insurance marketplace; and DPA, which administers state employees' health benefits. The SIM Office has contracted with CDPHE and OBH at CDHS for specific project deliverables, described elsewhere in this Operational Plan. However, most of Colorado SIM's collaboration with these agencies has been voluntary, and to date no formal regulatory arrangements have been instituted. If such arrangements are needed as SIM moves forward in implementing the model, the SIM Office will notify CMMI.

Coordination of Private and Public Efforts

The SIM Office has and will continue to actively engage private and public stakeholders in all stages of planning and implementation of the test model. The SIM governance structure purposely includes representatives of public and private organizations in all SIM workgroups, the Steering Committee, and the Advisory Board. Ongoing outreach and engagement with key stakeholders – public and private – will be critical to the achievement of SIM's vision.

The Colorado SIM initiative benefits from a strong history of public-private collaboration and innovation in the state. Colorado's insurers, providers, purchasers, patients, advocates, academics, and policymakers have worked together over the last decade, aided by strong support from the state's philanthropic community, to develop innovations to support health care transformation. Colorado SIM intends to leverage these public-private partnerships and collaborations to advance initiatives in several key program areas.

Practice transformation

Colorado SIM's practice transformation strategy, outlined in the ***Health Care Delivery System Transformation Plan*** section of the Operational Plan, builds on a strong foundation of federal, state and private sector investments in primary care transformation and integrated care. Currently, there are numerous public and private efforts underway in Colorado to integrate behavioral health and primary care, including a number of grant-funded pilot projects that test various approaches to integrating care. Many safety net providers are partnering with each other and with private providers to provide integrated care in their clinics. In addition, two pilot programs in western Colorado, one specific to Medicaid and one covering Medicaid and commercial members – both directed by Rocky Mountain Health Plans – are using global payments to support integrated care.

Colorado SIM's practice transformation work will build on these existing efforts. By including practices that have participated in other integration initiatives as part of its practice cohorts, Colorado SIM will incorporate the lessons learned and experience gained from other programs, and facilitate the sharing of best practices. Our goal is to knit various important initiatives into a comprehensive structure that leads to long-term health care delivery transformation.

In addition, SIM will leverage the work of multiple commissions, task forces, and other groups dedicated to bringing public and private entities together to address critical health care issues in the state. Examples of such efforts include:

Colorado Suicide Prevention Commission – The Suicide Prevention Commission serves as the interface between the public and private sectors in establishing statewide prevention priorities that are data-driven and evidence-based. By focusing on current resources and expanding the network of partnerships across the state, the commission enhances the efforts of Colorado's Office of Suicide Prevention and makes annual reports to the Governor as well as the General Assembly.

Colorado Commission on Affordable Health Care – The Colorado Commission on Affordable Health Care was created to comprehensively study the major and fundamental drivers of health care costs in Colorado. It is charged with making recommendations to transform the current health care system into one that is more cost effective, while improving the quality of health care in Colorado. The Commission's work will build on past successes while encouraging private sector initiatives to control costs and improve health care quality, to ensure all Coloradans have access to affordable and high-quality health care. The Commission is comprised of 12 members and five ex-officio members, and includes representatives of public and private organizations across the health care spectrum. The Commission actively seeks input and participation from members of the public.

Colorado Behavioral Health Transformation Council (CBHTC) – The CBHTC was created within the CDHS "to reduce the economic and social costs of untreated behavioral health disorders… [through] the systemic transformation of the behavioral health system from one that is fragmented and siloed into one that is streamlined, efficient, and effective for Colorado citizens."[5] The Council is charged with developing a strategic prioritization, planning, and

[5] Executive Order B 2010-001

implementation process to advise the Governor's cabinet on transforming Colorado's behavioral health system; making recommendations to the cabinet that encourage and promote collaboration, partnerships, and innovation across governmental agencies and other agencies in the budgeting, planning, administration, and provision of behavioral health services associated; and coordinating and consolidating the Council's efforts with the efforts of other groups that are working on behavioral health issues to increase the effectiveness and efficiency of these efforts. Council members include representatives from the state legislature, state agencies, and consumers or entities representing consumers of behavioral health services.

Substance Abuse Trend and Response Task Force – In 2013, the General Assembly reshaped and reauthorized the Colorado Methamphetamine Task Force as the Substance Abuse Trend and Response Task Force (Senate Bill 13-244), and expanded the group's scope to include: examining drug trends and the most effective models and practices for the prevention and intervention of substance abuse, and the treatment of children and adults affected by drug addiction; formulating responses to current and emerging substance abuse problems from the criminal justice, prevention, and treatment sectors; assisting local communities with implementation of the most effective practices regarding substance abuse prevention, intervention, and treatment; reviewing model substance abuse prevention, intervention, treatment, and interdiction programs that have shown the best results in Colorado and across the United States; evaluating and promoting approaches to increase public awareness of current and emerging substance abuse problems and strategies for addressing those problems; and measuring and evaluating the progress of the state and local jurisdictions in preventing substance abuse and non-FDA-regulated pharmaceutical drug production and distribution and in prosecuting persons engaging in these acts. The Task Force is comprised of 22 members including representatives from the Governor's Office, state agencies, law enforcement, service providers, and representatives from youth, substance abuse recovery, and community representatives.

Strategic Planning Group on Aging – The recently created Strategic Planning Group on Aging will analyze issues related to Colorado's aging population, develop a strategic plan, and make recommendations to the General Assembly regarding specific actions and bills.

Colorado Consortium for Prescription Drug Abuse Prevention – The Colorado Consortium for Prescription Drug Abuse Prevention was created in 2013 to establish a coordinated, statewide

response to the issue of prescription drug abuse. Its mission is to reduce the abuse and misuse of prescription drugs through improvements in education, public outreach, research, safe disposal, and treatment. The Consortium is housed administratively in the Skaggs School of Pharmacy and Pharmaceutical Sciences at the University of Colorado Anschutz Medical Campus, and provides an overarching infrastructure to link the many agencies, organizations, health professions, associations, task forces, and programs that are currently addressing the prescription drug abuse problem. The Consortium is organized into workgroups, which are responsible for implementing the major initiatives outlined in the Governor's Colorado Plan to Reduce Prescription Drug Abuse (health care provider education, public awareness, safe disposal, Prescription Drug Monitoring Program (PDMP) improvements, research/data sharing, and improving access and referrals to treatment; recently an additional initiative, increasing awareness of and access to naloxone, was added). In addition, the Consortium provides a broad range of innovative training experiences for professional and postgraduate students while facilitating development of new research programs that will lead to more effective prevention efforts, treatment protocols, and awareness of the problem of prescription drug abuse in Colorado.

Early Childhood Colorado Partnership

The Early Childhood Colorado Partnership (Partnership) is a network of more than 500 cross-sector partners from state and local agencies, nonprofits, early childhood councils, foundations, and universities committed to advancing the vision of the Early Childhood Colorado Framework statewide. The Partnership provides the space and conditions for diverse partners across the comprehensive early childhood system – encompassing physical, mental and behavioral health, family support, and early learning – to come together, identify common results, share best practices, implement strategies and track progress towards indicators of child, and family wellbeing and systems performance improvement.

The SIM Office will continue to engage with entities that provide a forum for public-private partnerships to identify points of intersection between programs and initiatives. Through these ongoing relationships, SIM will identify resources, programs, and services that can be leveraged to advance SIM initiatives, and reciprocally can offer support, and promote and disseminate the work of other organizations engaged in transforming the state's health care system.

Payment reform

Public and private payers in Colorado's market have a high degree of interest in supporting and paying for integrated care, and have already demonstrated a willingness to utilize alternative payment methods when practices are able and willing to accept non-Fee-For-Service payments. In 2011, Colorado Medicaid launched the ACC, an "Accountable Care Organization-like" pilot program designed to improve health while reducing costs by linking Medicaid clients with a medical home, and providing care coordination and connections to community resources through The Regional Care Collaborative Organizations (RCCOs). Several private payers have also launched company-specific initiatives involving components of integrated care delivery and/or payment reform. As part of recent legislation (HB 12-1281), Rocky Mountain Health Plans, a carrier on Colorado's Western Slope, is piloting a program that coordinates behavioral health and physical health through a complete transfer of risk and budget accountability to community partners.

Public and private payers were brought together under CPCI, a four-year multi-payer initiative designed and implanted by CMS to strengthen primary care through the provision of a core set of primary care functions. This joint participation gave rise to the Colorado Multi-Payer Collaborative, a self-funded, self-governing entity voluntarily formed by the payers to develop organizational alignment and consistency around the support of CPCI participating practices. For a detailed explanation of how Colorado SIM activities align with and build upon CPCI, please see the ***SIM Alignment with State and Federal Initiatives*** section of the Operational Plan.

The MPC has since expanded its mission to more broadly support primary care transformation activities in the Colorado marketplace. The group currently includes nine private payers and one public payer, and meets on a monthly basis. As of December 1, 2015, the SIM Office is working to finalize a MOU with members of the MPC, which will define the parameters of their participation. The Colorado SIM Office is also working with CMS to secure Medicare's participation in the MPC and the SIM initiative, so that our Model Test will include all of the major payers' in the state.

The Colorado SIM Office will build upon the foundation laid by CPCI and other pilot initiatives in the state, and leverage payers' commitments to migrate toward prospective, non-volume payments, as providers become capable of adopting these new payment models. The success of pilot initiatives will provide dependable evidence to additional private payers in the marketplace, and help spur further adoption of these forward-thinking payment models. Colorado SIM will continue to conduct broad outreach to the state's largest payers, and engage the self-funded business community to drive demand

for integrated behavioral health in the **Administrative Service Organization/Third Party Administrator** market, using the SIM initiative as a leverage point to ensure Colorado's premier innovations complement, rather than compete with each other.

Population Health

Establishing a strong and ongoing partnership between Colorado's public health system and the behavioral health and primary care sectors is crucial to SIM's efforts to address factors outside of the clinical setting – including social, economic, and environmental influences – that impact health outcomes. The ***Plan for Improving Population Health*** section of the Operational plan outlines how CDPHE has entered into a public-private partnership with the Denver Foundation to issue a joint RFA that supports population health collaboratives, which may include both public and private agencies working together to address behavioral health in their communities. Additionally, the ***Plan for Improving Population Health*** section indicates how Regional Health Connectors and the Colorado Health Extension Service (CHES) will be leveraged to facilitate partnerships between the public and private sectors. This section of the plan also indicates how a funding opportunity for LPHAs encourages partnership with other organizations, both public and private, to accelerate integration and reduce stigma.

Colorado also has several efforts under way to bring public health agencies and private-sector agencies and providers together to improve individual and population health. Examples of such activities include:

> **Northwest Colorado Community Health Partnership (NCCHP) Community Care Team (CCT) –** Members of the CCT, including LPHAs, federally-qualified health centers (FQHCs), CMHCs, community service providers, etc., encounter clients at different stages on the care continuum, and assist or refer them to the appropriate resources. Key elements of this model include: integrated behavioral health and primary care in FQHC and private primary care practices, using resources from CMHCs and Northwest Colorado Visiting Nurse Association; care coordination services for Medicaid clients, providing both primary and behavioral health care coordination; and 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 venture that brings together public and private health care providers (primary care, behavioral health, hospital, etc.) with the LPHA county commissioners, paramedics, and community service

providers. Its goal is a healthy population with 100 percent access to high-quality care at an affordable reduced cost, with a special emphasis on the underserved.

The Colorado Prevention Alliance (CPA) – This collaboration among state and local health agencies, Medicaid, private health insurers, providers, and purchasers 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 LPHAs. Initial tracking showed that an estimated 20 percent of immunization patients had some type of private insurance coverage. Multiple LPHAs were successful in contracting with private insurers, using a state-developed contract template.

Colorado SIM will support and reinforce existing partnerships, and work to achieve alignment between public and private payment strategies and public health initiatives, allowing for sustainability.

Health Information Technology

A central component of Colorado SIM is the expansion of the state's HIT infrastructure to support practice transformation, improve population health, develop shared care planning resources, expand telehealth, and coordinate public health services. As SIM works to create a fully-integrated electronic health care system with statewide reach, public and private collaboration will be essential to achieving our goals.

Office of eHealth Innovation

The recently created Office of eHealth Innovation, housed within the Governor's office, will play an important role in strengthening public-private collaboration around HIT initiatives within the state. The Office of eHealth Innovation is tasked with promoting and advancing "the secure efficient and effective use of health information" and coordinating "relevant public and private stakeholders and Health IT programs across state agencies and between state and federal projects."[6] The Office, along with a Commission appointed by the governor, will serve as Colorado's Designated Entity to participate in the programs of the Office of the National Coordinator for HIT and other federal HIT Programs.

[6] Executive Order B 2015-008

Public and private collaboration and coordination will figure prominently in several SIM HIT initiatives, including:

- **Data Acquisition, Aggregation, & Integration –** SIM will be working to collect, aggregate, and integrate clinical, behavioral health and claims data from multiple sources, both public and private, to analyze and report quality and cost measurements and to assess the completeness of the initiative's integrative efforts and ability to produce predictive analysis. All laws and rules regarding patient privacy will be followed;
- **Analytical Reporting –** The centralized data hub created under SIM will need the capacity to provide analytics and reporting for multiple end users, both private and public, including providers, payers, policymakers, and researchers;
- **Governance** – Policies, procedures, and protocols regarding the overall management of the availability, usability, integrity, and security of health information data in Colorado, developed through the SIM project in conjunction with the Office of eHealth Innovation and in accordance with federal standards and requirements, will apply to both public and private entities; and
- **Sustainability -** Colorado received federal, state and community funding to build and strengthen local HIT infrastructure, test innovations, and build Health Information Exchange (HIE) capacity; as these sources of grant funding come to an end, the state will need to find a financial mechanism for supporting and sustaining HIT and HIE systems, which will likely include contributions from public and private sources. A more detailed discussion of the Office of eHealth Innovation can be found in the HIT section of the Operational Plan.

Integration/Alignment with Existing Legislative and Executive Authority

The SIM Office has aligned planned transformation activities under the model test with existing legislative and executive authority. Colorado SIM is building on a legacy of strong executive leadership and action to improve the state's health care system, most recently under Governor John Hickenlooper. In addition, the state has a large and active community of advocacy groups, membership organizations, and non-profit interest groups. Health care has featured prominently in state legislative session, both before and after the passage of federal health care reform.

Legislation

Key pieces of legislation that set the stage for Colorado SIM include:

Senate Bill 06-208 – Established the bi-partisan, multi-stakeholder Blue Ribbon Commission for Health Care reform.

House Bill 08-1385 – Required health insurance plans to disclose price information – including the average reimbursement rates for the average inpatient day or the average reimbursement rate for the 25 most common inpatient procedures based upon the most commonly reported diagnostic-related groups – on the DOI's website in a manner that is easy to navigate and in language that is consumer-friendly.

House Bill 09-1293 – Known as the "Colorado Affordable Care Act," established a hospital provider fee that was matched by federal dollars to fund the expansion of Medicaid and Child Health Plan Plus and increased reimbursement rates.

Senate Bill 11-200 – Bipartisan legislation created the state health insurance exchange with support from insurers, business, advocates, and providers (Colorado was the first state in the nation to pass such legislation).

House Bill 12-1052 – Expanded, within limits, the state's ability to collect information about certain health care professionals' specialties, practice locations, and other pertinent information by authorizing the state's Division of Professions and Occupations (DPO) and Office of Primary Care (OPC) to request such data from primary care physicians, advanced practice nurses, and pharmacists when they renew their licenses.

House Bill 12-1281 – Directed CDHCPF to accept proposals for an innovative payment reform pilot that demonstrated new ways of paying for improved client outcomes while reducing costs. Under the first proposal selected, Rocky Mountain Health Plans (RCCO Region 1) will be piloting full risk, global payment within the ACC starting in 2014, in a program that includes behavioral health integration, global payments, and risk- and gain-sharing arrangements, which will allow payments to providers for value at the point of care;

House Bill 12-1288 – Administration of Information Technology Projects in State Government – Tasked the Governor's Office of Information Technology (OIT) with specific duties and responsibilities to help ensure the success of projects with an Information Technology component.

House Bill 13-1015 – Repealed the prohibition against the disclosure of small group mental health claims information to Colorado's All Payers Claims Database.

House Bill 13-1266 – Aligned Colorado health insurance laws with the health insurance marketplace reforms mandated by the Patient Protection and ACA, providing consumers, insurance carriers, agents, and other stakeholders with one set of health insurance rules; also creates a regulatory environment to support Connect for Health Colorado in becoming a new marketplace for health insurance in the state.

Senate Bill 13-200 – Expanded Medicaid coverage for low-income Coloradans beginning on January 1, 2014 to cover those with incomes up to 133 percent of the Federal Poverty Level (FPL). Some earning more may still qualify.

Senate Bill 13-266 – Directed CDHS to issue a request for proposals from entities with the capacity to create a statewide coordinated and seamless behavioral health crisis response system. The legislation resulted in the creation of a statewide crisis hotline.

Senate Bill 14-187 – Created the Colorado commission on affordable health care and required the Commission to study and make recommendations regarding health care costs. Its focus was on evidence-based cost controls, access, and quality of care.

Since the Colorado SIM proposal was submitted, additional legislative action that may impact the implementation of SIM initiatives has included:

House Bill 15-1029 – Health Care Delivery via Telehealth Statewide – Starting on January 1, 2017, health benefit plans can no longer require in-person care delivery when telehealth is appropriate, regardless of the geographic location of the recipient or provider of care, or the population size of the county in which the recipient resides. Providers will not need to demonstrate a barrier to in-person care exists for the telehealth coverage requirements to apply. In addition, carriers must reimburse providers who deliver care through telemedicine on the same basis as care delivered in person. Furthermore, they cannot apply cost-sharing arrangements to services delivered through telehealth that are not equally imposed on services delivered in person, and cannot impose an annual or lifetime dollar maximum that applies separately to telemedicine services.

House Bill 15-1032 – Additional Licensed Mental Health Professionals may Treat Minors – Allows other licensed mental health professionals, namely licensed social workers, marriage and family therapists, professional counselors, and addiction counselors, to provide mental health services to minors in addition to persons licensed to practice medicine or psychology.

House Bill 15-1033 – Strategic Planning Group on Aging – Establishes a strategic action planning group, appointed by the governor, to study issues related to the increasing number of Colorado residents 50 years of age and older and to issue a comprehensive strategic action plan on aging; directs specific areas for the group to analyze and to make recommendations, and establishes a cash fund to receive appropriations and gifts, grants, and donations to pay for the group‘s work.

House Bill 15-1067 – Continuing Professional Development Psychologists – Requires licensed psychologists to complete continuing professional development and educational hours to maintain licensure; directs the State Board of Psychologist Examiners to adopt rules establishing a continuing professional development program that includes: the development, execution, and documentation of a learning plan; a requirement that every two years a psychologist complete at least 40 hours of continuing professional development; and a requirement that psychologists maintain documentation of continuing professional development hours.

House Bill 15-1182 – Scope of Practice Certified Nurse Aides – Expands the scope of practice for certified nurse aides who are deemed competent by a registered nurse to perform certain tasks.

House Bill 15-1276 – Skilled Worker Outreach, Recruitment and Training – Creates the Skilled Worker Outreach, Recruitment, and Key Training Act, also referred to as the WORK Act, which establishes a matching grant program in the department of labor and employment to award matching grants to entities and organizations that offer skilled worker training programs to assist in their outreach, recruiting, and training efforts.

Senate Bill 15-015 – Mental health Parity for Autism Disorders – Starting on January 1, 2017, autism spectrum disorders will be included under the state‘s mental health parity law (the provision in current law that specifies autism is not to be treated as a mental illness for purposes of health care coverage will be repealed); under parity, the health care benefits for autism spectrum disorders can be no less restrictive than benefits available for a physical illness, and there cannot be caps on the number of services or visits covered under a health benefit plan for the assessment, diagnosis, and treatment of autism spectrum disorders.

Senate Bill 15-082 – County Workforce Development Property Tax Incentives – Authorizes a county to establish a workforce development program to provide financial assistance to high school graduates in the county who pursue post-secondary education or training from an accredited institution of higher education or certified training program. Any county that establishes a workforce development program

may also establish a workforce development fund to accept contributions for the purpose of the program. A county that has established a workforce development program can also offer incentives, in the form of a county property tax credit or rebate, to a residential or commercial property owner in the county who contributes to a county workforce development fund.

Senate Bill 15-197 – Advanced Practice Nurses Prescriptive Authority – Changes requirements for advanced practice nurses in the following areas: reduces the requirement to achieve full prescriptive authority from 1,800 hours of prescribing in a preceptorship and 1,800 hours of prescribing in a mentorship to 1,000 practice hours; allows the role of mentor to be filled by an advanced practice nurse with prescriptive authority and the same role and population focus as the applicant; allows synchronous remote collaboration during the mentorship; and allows provisional prescriptive authority upon graduation and passage of the certification examination.

Executive Orders

Key Executive Orders that have been recently signed include:

Executive Order B 2015-001 – Creating the Office of the SIM and the SIM Advisory Board

Executive Order B 2015-008 – Creating the Office of eHealth Innovation and the eHealth Commission

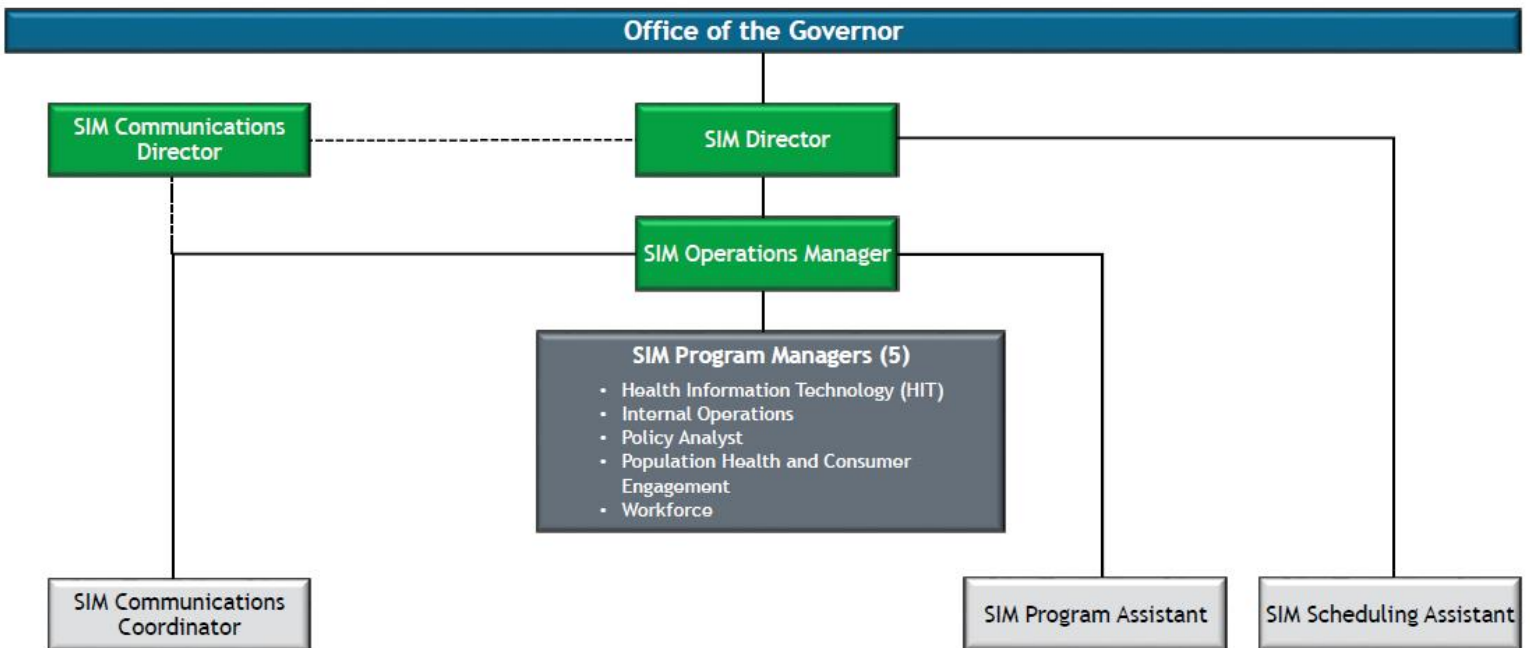
Recent legislative actions have established a legal and regulatory framework that will support SIM's efforts across multiple project areas, including telehealth, the expansion of scope of practice and licensure regulations, and mental health parity implementation. The SIM Policy Workgroup and the SIM Policy Analyst will monitor and leverage opportunities to utilize the legislative process as a mechanism for achieving SIM objectives and goals.

Roles and Responsibilities Staff and Contractors

SIM Office

With the exception of the SIM Office Director, the roles and responsibilities for all SIM Office staff – existing, new, and contracted – are clearly outlined in the job descriptions posted on the State of Colorado Jobs website (https://www.governmentjobs.com/careers/colorado). As part of the onboarding and orientation process, staff members have one-on-one meetings with the SIM Office Director and Operations Manager to review and clarify job responsibilities and expectations. Those responsibilities are also outlined in state-required position descriptions.

Since the pre-planning award funds were released on February 1, 2015, the SIM Office has hired nine full-time (1.0 FTE) positions. As new staff have been brought on board and the work of the SIM Office has accelerated, certain adjustments have been made to the roles and responsibilities of previously-existing positions. Any such changes have been determined by the Director and Operations Manager, and clearly communicated to both the staff member involved and the entire team. Additional staffing needs, and/or adjustments to current positions, will be evaluated on an ongoing basis.



For state staff who are contributing to SIM work as a percentage allocation of their overall work duties, the specific roles and responsibilities related to SIM are determined by the SIM Office and the state agency of employment.

- Creation of a detailed position description;
- Posting the description on the State of Colorado Jobs website for the requisite time period;
- Reviewing applications received and identifying the top candidates for phone and in-person interviews; and
- Conducting interviews to evaluate skills and subject matter expertise.

External Contractors

The roles and responsibilities of the contractors retained to support Colorado SIM work are clearly articulated in the executed contract between the state and the contractor. All contracts go through the state procurement process, and are reviewed and approved by CMMI.

Recruitment of Staff in Support of SIM activities

SIM Office

The Colorado SIM Office has followed State Agency protocols to recruit and hire new staff. The SIM Office also has reached out to local education institutions, to recruit master's students who would be interested in assisting with SIM activities as a way to complete certain program requirements (e.g. a practicum).

SIM staffing has been completed over a nine-month period. However, as the SIM Office moves from the planning to implementation phase of the initiative, staffing needs have been identified and must be promptly mitigated to ensure the efficiency and success of Colorado SIM. This includes a greater administrative force to assist with organization processes, procedural development, documentation, stakeholder engagement, and invoicing. Other needs include grants administration support, to assist with the process of navigating Grants Solutions, reviewing NOA needs, restrictions, and facilitating on-going communication with CMMI. Additionally, a data analyst is needed to manage, navigate, and report on various data streams measuring practice performance and overall SIM performance as this data becomes available. These staffing needs have arisen as the SIM Office has engaged in a reassessment process to replace the SIM Internal Operations Manager and Communications Director Positions that were vacated last quarter and are vital to the success and daily operation of the SIM initiative. These staffing needs are commensurate with SIM initiatives in other states.

External Contractors

External contractors have been identified through the State's competitive procurement process. In instances where a specific vendor has unique qualifications to execute specific SIM deliverables within a required time frame, a sole source model may be pursued, as allowed by state guidelines.

Staff Training and Support

SIM Office

All new staff members undergo orientation at the CDHCPF, and received training on the Colorado Open Records Act, the Americans with Disabilities Act, and the Health Insurance Portability and Accountability Act, among others.

SIM staff receive additional job training by attending Workgroup meetings, reading background materials, and shadowing other staff members. The SIM Office has developed a set of office policies and procedures, stored online, which detail the protocols for common daily tasks (e.g., setting up meetings, reserving conference lines, etc.). New staff members are encouraged to reach out to SIM's extensive network of stakeholders and to other individuals, agencies, and organizations in the state pursuing similar initiatives to gain background knowledge and additional subject-matter expertise.

Staff members regularly share information, key articles or news stories, research findings, etc. with one another, creating a constant learning environment. Many attend local conferences or participate in online webinars, and share notes and/or slide presentations with one another. Staff are also oriented to the technical assistance resources available through CMMI.

The SIM office holds weekly staff meetings, which allow team members to brief each other on current activities and upcoming events and coordinate efforts on short- and long-term projects. The small number of staffers and the broad and complex nature of the work make collaboration and teamwork essential skills. Staff members are expected to hit the ground running, but are given the support and resources needed to be successful.

External Contractors

External contractors do not receive formal training, but are expected to abide by all contract terms. Contracts clearly describe requirements/expectations regarding ongoing engagement with the SIM Office in the form of weekly status calls/updates, attending workgroup meetings, and incorporating feedback from SIM stakeholders into contract execution and deliverables, as applicable.

Monitoring of Continuous Quality Improvements Efforts

A detailed description of SIM's methods for monitoring quality improvement efforts can be found in the ***Program Monitoring and Reporting*** section of the Operational Plan.

Component Summary Table

SIM Component/Project Area: *Governance*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Maintain ongoing communication with the Governor's Office, and ensure coordination/alignment of SIM with the Administration's other statewide initiatives and priorities around health	• Participate in Governor's Health Cabinet and Workforce Cabinet meetings • Bi-weekly meetings between the Governor's Senior Health Policy Advisor and SIM Policy Analyst • Provide regular progress/status updates on SIM activities; coordinate with other Governor's Office programs & priorities	SIM Office	Practice Transformation; Payment Reform; Population Health; HIT	Participate in scheduled meetings; coordinate and align strategies and communications/ messaging
Provide continued guidance, oversight of SIM Workgroup, Steering Committee, and Advisory Board meetings	• SIM Office staff will attend and provide administrative support, facilitation of all meetings • Manage workgroup membership, filling vacancies and making adjustments as needed, to ensure adequate representation from a diversity of organizations	SIM Office	Practice Transformation; Payment Reform; Population Health; HIT	Appropriate SIM staff members will attend all scheduled Workgroup, Steering Committee, and Advisory Board meetings; Workgroup membership will be maintained over the course of the Model Test

SIM Component/Project Area: *Governance*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Maintain private-public engagement in SIM's major project components – including payment reform, practice transformation, population health, and health information technology – and coordinate/align SIM activities with other private-public efforts in the state	• Coordinate and align SIM activities in all program areas with other key private/public partnerships in the state • SIM Director will continue to participate in meetings of the Colorado Multi-Payer Collaborative • Engage with the Colorado Business Group on Health and other ASO/TPA and self-insured employers, to educate and inform them of SIM activities and garner support to help drive demand for integrated care and alternative payment models • Ongoing oversight of the execution of University of Colorado, Colorado Department of Public Health and Environment and Office of Behavioral Health contracts involving practice transformation and population health, to ensure vendors are establishing/maintaining private-public participation and coordination as appropriate • Work with selected HIT vendors, the Office of eHealth Innovation, state agencies, and state HIT organizations to develop a governance structure and sustainability plan that includes public-private participation	SIM Office; University of Colorado; Colorado Department of Public Health and Environment; Office of Behavioral Health	Practice Transformation; Payment Reform; Population Health; HIT	Maintain existing and develop additional relationships with existing public-private partnerships, and establish new areas of collaboration and engagement

SIM Component/Project Area: *Governance*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Monitor and track proposed legislation in the Colorado General Assembly that may impact SIM activities and objectives	• SIM Policy Analyst will meet regularly with state agency legislative liaisons to identify areas of alignment with SIM • SIM Policy Workgroup will serve as a forum for discussing potential and introduced legislation, and develop strategies and recommendations to mitigate potential risks and capitalize on opportunities • SIM Office will work with stakeholders to develop legislative proposal, as appropriate, that would facilitate/support the advancement of care delivery and/or payment reform efforts	SIM Office	Practice Transformation; Payment Reform; Population Health; HIT	Monitor the legislative, regulatory, and administrative context in which SIM operates; identify potential barriers; and identify opportunities to promote/advance integrated care and alternative payment models
Oversee execution of current and future contracts for SIM deliverables	• Continue ongoing communication with all vendors, through regularly scheduled phone calls and meeting • Proactively identify potential problems or delays	SIM Office	Practice Transformation; Payment Reform; Population Health; HIT	Maintain ongoing communication with vendors and CMMI; proactively identify potential issues; ensure contract deliverables are on time and high quality
Maintain adequate staffing of SIM Office through hiring, retention, and training procedures	• Follow state hiring processes and procedures • Develop robust recruitment and retention policies • Provide staff with adequate training, support	SIM Office	Practice Transformation; Payment Reform; Population Health; HIT	Maintain appropriate SIM Office staff; make adjustments as needed/appropriate

Stakeholder Engagement

Convening SIM Stakeholder Workgroups

Current State

The principal avenue for engaging stakeholders is through the regular convening of the following eight topic-specific workgroups:

- Consumer Engagement;
- Evaluation;
- Health Information Technology;
- Payers and Payment Reform;
- Policy;
- Population Health;
- Practice Transformation and Service Delivery; and
- Workforce Development.

Workgroups meet at least once per month and serve as both a vehicle for disseminating information to stakeholders as well as a forum for actively engaging stakeholders in making recommendations to the SIM Office. While dozens of workgroup meetings were held leading up to and beyond the award date of February 1, 2015, in order to refocus stakeholders' attention toward implementation rather than design of the SHIP, workgroups were reformed. Between June 1, 2015 and November 30, 2015, some 70 stakeholder workgroup meetings were held.

Workgroups consist of about 17 members each for a total of 138 participants. Members were selected in an open and competitive application process, based on their subject-matter expertise and ability to represent key stakeholder groups across the state. Membership was limited to underscore the importance of participation (members are required to attend 75 percent of all workgroup meetings) and to support the nimbleness required to quickly operationalize the SHIP.

For additional details regarding workgroup structure and how workgroups interface with the broader Colorado SIM governance model, see the ***Governance, Decision-Making, and Stakeholder Representation*** section of the Operational Plan.

Demonstration of Diversity

The Colorado SIM Office made extensive efforts to assure that workgroup membership was representative of race, gender, and Colorado's diverse geography, and was inclusive of a wide variety of public and private organizations.

The following table demonstrates the distribution of agencies with at least one representative on a SIM Stakeholder workgroup. Agencies reflect those with a healthcare focus as well as those that represent broader topics and interests that support the overall objectives of Colorado SIM. As current members drop off and new members are selected to replace them, the SIM Office will make every effort to preserve diversity of workgroup membership.

Commercial Payers/Purchasers
Anthem
Colorado Access
Colorado Association of Health Plans
Delta Dental of Colorado
Kaiser Permanente
Rocky Mountain Health Plans
UnitedHealth Group
Community-Based and Long Term Support Providers
Community Health Partnership
Grand County Rural Health Network
Greater Metro Denver Healthcare Partnership
North Colorado Health Alliance
Servicios de la Raza
The Chronic Care Collaborative
Consumer Advocacy Organizations
Alliance Colorado
Colorado Center on Law and Policy
Colorado Coalition for the Medically Underserved
Colorado Health Initiative
LiveWell Colorado
Mental Health America of Colorado
Oral Health Colorado
The Arc of Colorado
Colorado Criminal Justice Reform Coalition
Health Systems and Providers
Arapahoe/Douglas Mental Health Network
Arapahoe House

Axis Health System
Boulder Community Health
Centennial Mental Health Center, Inc.
Centura Health
Children's Hospital
Deb Parsons, MD, LLC
Denver Health
Denver Indian Health and Family Services
Foresight Family Physicians
High Plains Community Health Center
Jefferson Center for Mental Health
Kaiser Permanente
Mental Health Center of Denver
Northwest Colorado Visiting Nurse Association
Sunrise Community Health Center
Swedish Medical Center Family Medicine Residency
The Denver Hospice
University of Colorado Health (UCH)
Recovery Center
Indian Health and Family Services, Inc.

Higher Education

University of Colorado College of Nursing
University of Colorado School of Medicine
Red Rocks Community College
Regis University
University of Denver, Graduate School of Social Work

Local Public Health Agencies

Boulder County Public Health
Eagle County Public Health and Environment
El Paso County Public Health
Health District of Northern Larimer County
Jefferson County Public Health
Tri-County Health Department

State Agencies

Colorado Department of Human Services
Office of Governor John Hickenlooper
Colorado Department of Health Care Policy and Financing
State Senate
Colorado Department of Labor and Employment
Colorado Department of Public Health and Environment
Colorado Department of Regulatory Affairs

Other
Caring for Colorado Foundation
Center for Improving Value in Healthcare
Colorado Regional Health Information Organization (CORHIO)
Engaged Public Consulting
HealthTeamWorks
Integrated Community Health Partners
Milliman
Quality Health Network
Rose Community Foundation
ValueOptions
Colorado Community Managed Care Network

Strategy for Future Engagement

Continued Convening of Workgroups:

The SIM Office will continue to regularly convene workgroups, at least once a quarter, but more often when needed, until the end of the SIM grant. In the first year, the SIM Office anticipates that most workgroups will convene at least once per month.

Finalization of Workgroup Objectives

In consultation with workgroup members, the SIM Office has drafted the following objectives for each SIM workgroup. These drafts will be returned to workgroup members for final comment and a SIM Charter document, including all workgroup objectives, will be produced and posted to the SIM website by January 31, 2016.

This strategy is intended to give workgroup members clear direction regarding objectives of their engagement, mitigating the risk of burnout or workgroup fatigue that could result from a lack of clear direction.

Consumer Engagement

The Consumer Engagement Workgroup will ensure that the needs and perspectives of consumers inform all aspects of Colorado SIM's work. Specific objectives are to:

- Consult and advise other workgroups, the SIM Advisory Board, and the SIM Office on consumer engagement-related issues;
- Take on periodic ad hoc assignments related to consumer engagement, as assigned by the SIM Office;

- Make recommendations about how integration of physical and behavioral health could improve the consumer experience; and
- Ensure that consumers are part of the SIM process and that their interests and needs are met.

Evaluation

The Evaluation Workgroup will provide recommendations regarding how to effectively measure and evaluate the outcomes of the SIM Initiative. Specific objectives are to:

- Finalize an external evaluation plan that assesses the effectiveness of SIM interventions outlined in the SIM proposal to CMMI;
- Create a quantifiable set of metrics that measures processes and outcomes on both the individual and population level;
- Provide feedback on external evaluation contractor deliverables, including evaluation framework, methodology, data analysis plan and reports; and
- Make recommendations to implement rapid-cycle improvements to identified measures.

Health Information Technology

The HIT Workgroup will provide recommendations and requirements so that those charged with implementing health-related Information Technology solutions, tools, and systems can complete work in support of the SIM objectives. It is anticipated that most if not all Workgroups will have technical needs, and may need the advisory expertise of this Workgroup. Specific objectives are:

- Develop a Quality Measurement Assessment Tool;
- Expand telehealth capabilities throughout the state, including broadband expansion; an implementation strategy, including technical assistance for providers; and the establishment of Telehealth Resource Centers aligned with Regional Health Transformation Collaboratives,
- Acquire and Aggregate clinical and behavioral health data;
- Integrate claims data, resulting in the analytical capability to evaluate electronic CQMs and deliver value based payment models;
- Create the integrated data infrastructure with robust data quality standards, including clinical, behavioral health data, and claims data, to support population health; and
- Create reports and the capability to disseminate data to other sources or data stores.

Payers and Payment Reform

Composed of representatives from multiple public and private payers, purchasers, and community stakeholders, the Payers, Purchasers, and Payment Reform Workgroup will provide recommendations on designing alternative payment models that support the integration of behavioral health and clinical care. Specific objectives are to:

- Develop a definition of key terminology related to payment models;
- Collaborate with other workgroups to define a set of common measures related to payment reform;
- Clarify how SIM will define and measure its goal of providing 80 percent of Colorado residents with access to healthcare services in coordinated systems, with value-based payment structures, and identify key steps toward achieving this goal; and
- Recommend minimum criteria for participation in practice transformation cohorts.

Policy

The Policy Workgroup will assess the legislative, regulatory, and administrative context in which SIM operates. Specific objectives are to:

- Identify policy barriers that may impede the progress of various SIM initiatives and make recommendations regarding how these challenges can be overcome;
- Stay informed of any current or proposed changes to state or federal law that may impact SIM goals and objectives and report the opportunities and/or risks presented by such changes to the SIM Office;
- Monitor other state and federal reform initiatives to ensure that SIM policy approaches/actions are in alignment with other health care innovation efforts;
- Make recommendations on new policies that should be implemented to support advancement of SIM goals; and
- Develop an overarching policy framework that: a) facilitates future stakeholder collaboration and alignment around state health policies and initiatives, b) fosters and supports innovative, evidence-based, person-centered methods of delivering and paying for health care services, and c) provides a sustainable pathway for achieving the state's short- and long-term objectives around health and wellness, both now and in the future.

Population Health

This Population Health Workgroup will work to ensure that SIM Interventions improve health outcomes at the community and population level. Specific objectives are to:

- Define "population health" and associated terms as they relate to the SIM Initiative;
- Ensure that SIM strategies and approaches address the social determinants of health;
- Work with the evaluation workgroup and Steering Committee to align population-based metrics with indicators of success at the individual level;
- Recommend strategies to reduce stigma regarding behavioral health at both the individual and population levels in the State of Colorado;
- When requested, provide guidance on the best manner to achieve deliverables outlined in the Interagency Agreement between the SIM Office and the CDPHE; and
- Provide recommendations regarding the inclusion of public and community health initiatives in the work of Regional Health Connectors.

Practice Transformation and Service Delivery

The Practice Transformation Workgroup will develop strategies to improve and integrate health care across approximately 400 practices and four CMHCs chosen to participate in transformation efforts throughout Colorado. Specific objectives are to:

- Collaborate with HIT, Population Health, Payers and Evaluation workgroups to determine minimum criteria for participation in practice transformation cohorts;
- Ensure that practices chosen for participation represent a variety of affiliation models (independently owned vs. system affiliated) and reflect the diversity of the geographies and populations they serve;
- Make recommendations regarding the definition of practice transformation and what specific interventions transformation efforts will include; and
- Recommend a set of practices for each transformation cohort.

Workforce

The Workforce Workgroup will assess and plan for the development and standardization of the workforce needed to effectively deliver integrated care. Specific objective are to:

- Make recommendations regarding minimum qualifications, credentialing, training, and job descriptions for new positions within the workforce (e.g. Regional Health Connectors);

- Offer guidance on the best manner of delivering training to existing providers in order to promote successful integration of behavioral and physical health; and
- Propose strategies that create standardization in the way that existing, but largely unregulated positions (e.g. Community Health Workers [CHWs]), interact with health care integration efforts throughout Colorado.

Tracking Progress and Key Dependencies across Workgroups

Each SIM Office staff member who supports a workgroup will complete a monthly status report that outlines the progress of the workgroup. The report will also include key dependencies, to be shared with other workgroups, as well as identify possible risks and mitigation strategies. Status reports will be reviewed by the SIM Operations Manager.

Leveraging Other Stakeholder Groups

The Colorado SIM Office recognizes that a wide array of active stakeholder groups have already been convened to help accelerate statewide health transformation. Rather than relying entirely on SIM workgroups and events, the SIM Office also seeks to collaborate with and leverage the capacity of these existing forums for stakeholder engagement.

Current State

SIM staff members regularly participate in a wide range of stakeholder groups convened by other organizations. Key examples include:

- Health Cabinet Meetings (convened by Governor's Office);
- Workforce Cabinet Meetings (convened by Governor's Office);
- Colorado Health Extension System (convened by University of Colorado, Department of Family Medicine);
- MPC Meetings (in conjunction with the CPCI); and
- State Designated Entity (SDE) Action Committee (State HIT Steering Committee).

Strategy for Future Engagement

In addition to continuing engagement in the meetings above, the SIM Office will seek to expand its partnership with other stakeholder groups. Key examples of future collaboration include:

Medical Home Community Forum

Convened by CDPHE, the Medical Home Community Forum meets on a quarterly basis to engage agencies, families, medical facilities, organizations and policymakers from all over Colorado in implementing the Patient Centered Medical Home (PCMH) model. In order to promote alignment between Colorado PCMH initiatives and integration efforts through SIM, the Colorado SIM Office has committed to presenting at all future community forum meetings over the course of the grant.

At the September, 2015 meeting, SIM Office Staff gave an overview of the initiative and, in conjunction with partners at CDPHE, provided an update on population health activities, including the anticipated launch of the Population Health Community Collaboratives RFA. SIM Office and CDPHE staff have continued to meet and have outlined the following meeting schedule:

December, 2015 – SIM and ACCs: Joint discussion between ACC and SIM. Discussion will focus on identifying areas of synergy between the initiatives and promoting alignment, with an emphasis on practices that may receive enhanced payments through both initiatives.

March, 2016 – SIM and LPHAs: SIM and CDPHE to focus meeting on LPHAs and Population Health Collaboratives funded by SIM. The discussion will be used to coordinate efforts and to identify how the public health system can support a medical home model.

June 2016 – Focus on Evaluation: The to-be-hired SIM evaluation contractor will present to practices on alignment of metrics and standards across payers.

September 2016 – Early Lesson from Cohort 1: This forum will focus on garnering feedback from practices that participated in the first SIM cohort and asking them to share best practices and lessons learned with practices that may consider joining Cohort 2.

Utilizing Other Consumer Groups

The Colorado SIM Office recognizes that although members of the Consumer Engagement workgroup possess expertise in the field of consumer advocacy, they do not necessarily reflect the views of the entire consumer population, particularly those who are publicly insured. As a result, The Colorado SIM Office has reached out to CDHCPF’s Stakeholder and Client Engagement Strategy Manager to identify avenues for vetting messages, materials, and decision items through consumers who are not directly involved with SIM. One avenue identified was the Person and Family-Centeredness Advisory Council, which directly engages Medicaid and Child Health Plan Plus consumers during monthly in-person meetings as well as through a virtual advisory council. Additionally, CDHCPF provided the SIM office with

a database of over 40 standing meetings that engage consumers and stakeholders on specific topics. The SIM Office intends to leverage these groups in order to garner consumer guidance and feedback on topics pertinent to the implementation of SIM.

Because CDHCPF councils and workgroups are limited to individuals enrolled in Medicaid or Child Health Plan Plus and their family members, the SIM Office is currently working with CDPHE and CDHS to identify avenues for engaging consumers that represent a variety of insurance statuses. The SIM Office will leverage these groups once identified, in order to ensure that a broad range of perspectives are considered.

Engaging Tribes and the American Indian Population

Current State

Coordination with Denver Indian Health and Family Services, Inc.

The SIM Office recognizes the importance of engaging tribes and the American Indian Population throughout Colorado in its work. The Colorado SIM Director has presented an overview of SIM to a stakeholder group convened by Denver Indian Health and Family Services, Inc. and has held several other meetings with leaders affiliated with this group. Additionally, a Board Member of Denver Indian Health and Family Services sits on the Consumer Engagement workgroup.

Strategy for Future Engagement

While the Colorado SIM Office will maintain its relationship with Denver Indian Health and Family Services, it also seeks to expand its engagement beyond the Denver metro area. In particular, further efforts will focus on engaging the Southern Ute and Ute Mountain Ute tribes.

Tribal Consultations

To date, CDHCPF, CDHS, and CDPHE have signed agreements with the two tribes stating that they will hold regular tribal consultations, defined by the *State-Tribal Consultation Guide* as "the open and mutual exchange of information integral to effective collaboration, participation, and informed decision making, with the ultimate goal of reaching consensus on issues. Consultation is the development of a relationship based on trust, an effort to understand and consider any effects an undertaking may have on the consulting parties."[7] The Colorado SIM Director will participate in the next tribal consultations, to

[7] Department of Health and Human Resources, Health Resources Services Administration. "Tribal Consultation Policy." http://www.hrsa.gov/publichealth/community/indianhealth/tribalconsultationpolicy.pdf

be held by early 2016. After this initial consultation, the Colorado SIM Office and two tribes will determine how best to continue engagement – be it through formally entering into an agreement to continue consultations or via other avenues.

Engaging the General Public

Current State

SIM Website

In July, the Colorado SIM Office launched a new website: www.colorado.gov/healthinnovation

The website serves as a central platform for posting public-facing information, including:

- Advisory Board, Steering Committee, and Workgroup Rosters;
- Open Funding Opportunities (RFAs, RFPs, RFIs, etc.);
- Colorado SIM Resources (FAQs, one-page overviews, etc.);
- SIM Newsletters and other health care transformation news; and
- Public Meeting Information (detailed below).

Public Meetings

All workgroup, steering committee, and Advisory Board meetings are open to members of the public. The SIM Office commits to maintaining the following process for communicating information about meetings:

- **Notification of Meetings:** All public meetings are posted on the calendar section of the SIM website at least two weeks in advance of the meeting. Interested parties are able to subscribe to receive any updates to the SIM Calendar via Rich Site Summary (RSS) feed or by syncing their personal calendars with the SIM calendar via iCal, ensuring that they remain apprised of updates.
- **Statewide Participation:** All public meetings provide the ability to participate via phone and/or webinar, so that both workgroup members and members of the public can participate from outside the Denver metro area.
- **Public Comment Period:** All public meetings include a designated period for public comment, and in certain cases, members of the public may be invited to participate throughout the meeting.

- **Meeting Recordings and Minutes:** Minutes and an audio recording of every meeting are posted on the SIM website within one week of each meeting. (Every effort will be made to post audio recordings within one business day of the meeting.)

SIM Video

In October 2015 the Colorado SIM Office produced a video featuring Governor John Hickenlooper and others active in SIM that provides an overview of SIM and its importance to the state. The Colorado SIM office is currently distributing the video to stakeholders and media outlets across the state, and believes it will generate awareness and interest among the public. The video is accessible online at: https://youtu.be/d0r9FMOq-Ws.

Other Communication Avenues

Additionally, the Colorado SIM Team maintains an active Twitter account (@SIM_Colorado) and mails a monthly newsletter via Constant Contact to a list of more than 1,000 subscribers. The newsletter is used to communicate key updates, such as the release of RFPs and upcoming deadlines.

Strategy for Future Engagement

Articulation of Workgroup Strategies

In response to stakeholder feedback indicating the need for clear, concise summaries of the overall SIM Strategy, the SIM Office will be developing a “strategy on a page” for each stakeholder workgroup. These documents will outline the major activities of each workgroup and detail specific ways in which they will help to achieve the SIM Triple Aim. Documents will be posted and publicly available on the SIM website.

Logging Public Comment

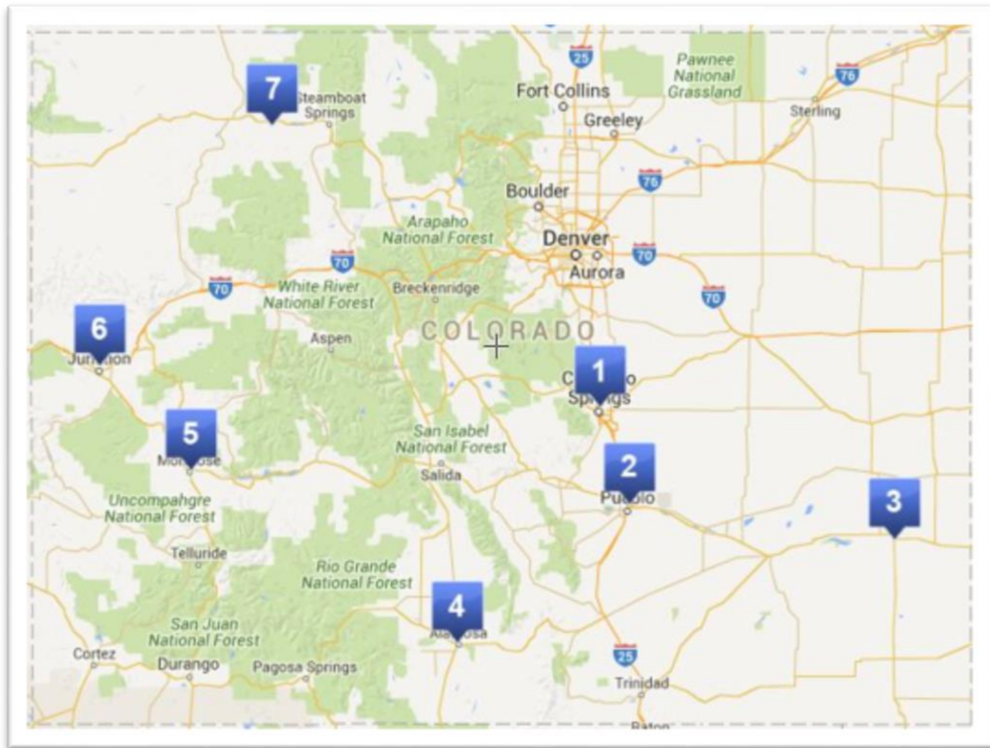
Members of the public can submit questions or comments through the SIM website as well as offer comment during public meetings. However, there is currently no way of logging these comments or tracking who responded to them. The SIM Office will create a public comment log in which these comments can be tracked, allowing staff members to identify particular trends or themes that need to be addressed and ensuring that commenters receive a timely response.

Annual SIM Outreach Tour

The SIM Office has committed to implementing an annual SIM Outreach Tour in which key members of the SIM Staff will engage stakeholders outside of the Denver Metro Area in their local communities. From November 9 – 13, 2016, the SIM Office conducted its first statewide tour, aimed engaging urban,

non-Denver/Metro, rural, mountain, and pioneer communities around the state. SIM staff and key community-based stakeholders gave presentations in the following communities:

1. Colorado Springs (Urban – South Central);
2. Pueblo (Urban – South);
3. Lamar (Pioneer – Eastern Plains);
4. Alamosa (Rural - Southwest);
5. Montrose (Rural - West Central);
6. Grand Junction (Urban – Western Slope); and
7. Hayden (Rural – Mountain Northwest).



While the first Outreach Tour focused on orienting community members to Colorado SIM, each presentation included time for community conversations. Community members were asked to provide feedback on how SIM could best engage with their communities as well as to identify local and regional initiatives that may provide opportunities for interfacing with Colorado SIM in the future.

In total, more than 100 stakeholders attended the presentations. These stakeholders represented a variety of public and private entities, including but not limited to FQHCs, CMHCs, hospital systems, HIEs, independent practices, health plans, LPHAs, county social service agencies, and members of the public.

In early 2016, the Colorado SIM team intends to travel to the Southwest and Northeast corners of the state in order to ensure maximum coverage for initial outreach. In future years, Outreach Tours will focus on bringing together SIM-funded primary care practices, CMHCs, LPHAs, and other key entities for regional conversations about how to best align efforts.

SIM Conference

The Colorado SIM Office will convene an annual conference of SIM stakeholders in a central location. The conference will bring together representatives from the HIT, public health, primary care, and behavioral health sectors as well as other relevant parties. Individuals representing efforts that align with Colorado SIM, such as the ACC, will be invited to attend as well. The focus of the conference will be on sharing lessons learned and promoting partnership and coordination between agencies. While the initial SIM narrative indicates that a conference would be convened every six months, feedback from the first SIM Outreach Tour mentioned above indicated that regional convenings that address local needs would be more effective than centralized conferences. In order to balance the need for local flexibility with overall program standardization, the Colorado SIM office will hold regional Outreach Tours yearly and a main SIM conference in Denver once every year as well.

Incorporating the Consumer Perspective

The SIM Office is committed to taking into account consumer needs, wants, and preferences in all aspects of its work. Colorado SIM has taken the following steps to ensure that the consumer voice is included and heard throughout decision-making processes.

Consumer Representation on the SIM Advisory Board

At the first SIM Advisory Board meeting, held in June 2015, members of the public were asked to weigh in on whether the Advisory Board needed to include greater representation of a specific group or interest. The SIM Office collected responses and identified common themes. The most commonly identified need was inclusion of consumer representatives on the Board.

As a result, the SIM Executive Order was amended to add four new positions to the Advisory Board, two of which were reserved for candidates who represented consumer interests. The Governor's Office of Boards and Commissions ran a competitive application process and selected the following two representatives to fill these slots:

- **Consumer Representative:** Carol Meredith, Executive Director, Arc of Arapahoe & Douglas County; and

- **Consumer Representative:** Carol Pace, FACMPE, Volunteer Advocate for AARP and the Colorado Consumer Health Initiative.

(For a complete list of SIM Advisory Board Members, see ***Appendix A.***)

The SIM Office believes that the addition of two consumer representatives to the Board will help to ensure that consumer perspectives are considered in all major decisions moving forward.

Identification of Consumer Engagement Priorities

During August and October the SIM Consumer Engagement workgroup convened to identify priority areas related to consumer engagement. The group used a literature review of other consumer priority surveys, a memo on methods of measuring consumer engagement prepared for the SIM Office by The Center for Health Care Strategies, as well as the personal experience and expertise of workgroup members to inform the discussion. The group identified the following priority areas related to consumer engagement that will support efforts to integrate behavioral and physical health care:

Access to Care	Effectiveness of care	Respectfulness of Care	Privacy/ confidentiality
• Ability to access care without having a psychiatric diagnosis first • Availability of services for Limited English Proficiency patients • Affordability of care • Reduction of payer fragmentation • Reduction of stigma as a barrier to access	• Continuity of care • Client feels informed about his/her care • Safety • Family involvement • Care is person-centered • Patient activation/ empowerment	• Use of respectful, person-first language by providers and staff	• Client has ability to access his/her information and can choose to share it with family and caregivers • Client's information is not shared with unwanted parties

The SIM Office will distribute these priority areas to all workgroups and identify ways in which each workgroup can contribute to setting and achieving related goals. The Program Manager for Consumer Engagement will keep a quarterly log of efforts that relate to these priorities as a means of tracking progress.

Requirements of Participating Payers

The Colorado SIM Office has chosen to include this information in the ***Payment and Service Delivery Models*** section of the Operational Plan.

Requirements of Participating Providers

The Colorado SIM Office has chosen to include this information in the ***Health Care Delivery System Transformation Plan*** section of Operational Plan.

Agreement between Payers and Providers

The Colorado SIM Office has chosen to include this information in the ***Payment and Service Delivery Models*** section of the Operational Plan.

Component Summary Table

SIM Component/Project Area: *Stakeholder Engagement*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Convene health care transformation stakeholders	Routinely scheduled stakeholder workgroup, steering committee and advisory board meetings	Rebound Solutions (steering committee facilitation); Civic Canopy (Advisory Board facilitation); SIM staff for workgroup facilitations	Practice Transformation, HIT, Population Health, Payment Reform	All workgroup, steering committee and advisory board meetings occur a minimum of four times per year
Public Meeting Calendar	Maintain a calendar of all public meetings on the SIM website, to which members of the public can subscribe via RSS feed or iCal for updates	SIM Office Staff	Practice Transformation, HIT, Population Health, Payment Reform	Meetings are routinely posted to SIM website in advance of the meeting date
Posting of Meeting Minutes and Recordings	Stakeholder meeting minutes and audio recordings posted to the CO SIM website	SIM Office Staff	Practice Transformation, HIT, Population Health, Payment Reform	Stakeholder meetings minutes and recordings are posted to SIM website at least one week in advance of the meeting
Quarterly SIM Newsletter	The SIM Office will produce and send a quarterly newsletter, via email, to all subscribers (currently 1000+) on its Constant Contact list	None (SIM Office Staff)	Practice Transformation, HIT, Population Health, Payment Reform	Newsletter sent every quarter

SIM Component/Project Area: *Stakeholder Engagement*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Medical Home Community Forum	SIM Office to co-host and present at all quarterly Medical Home Community Forum Meetings	None (SIM Office Staff)	Practice Transformation, HIT, Population Health, Payment Reform	SIM staff active in hosting 100% of Medical Home Community Forum Meetings, anticipated to last at least two years
SIM Charter Document	Public document that outlines SIM structure and all workgroup objectives	None (SIM Office Staff)	Practice Transformation, HIT, Population Health, Payment Reform	SIM Charter produced and made publicly available on SIM website by January 1, 2016
Articulation of SIM Strategies	Creation of "Strategy on a Page" documents that outline key activities of each workgroup and how they advance the Triple Aim	None (SIM Office Staff)	Practice Transformation, HIT, Population Health, Payment Reform	Eight "Strategy on a Page" documents published to the SIM website by March 1, 2016
Identification of Direct Consumer Group(s)	In addition to groups that can be leveraged through HCPF, the SIM Office will identify groups of consumers, who reflect a variety of insurance statuses, to provide feedback on SIM materials and decisions, as needed	None (SIM Office Staff)	Practice Transformation, HIT, Population Health, Payment Reform	By June 1, 2016

SIM Component/Project Area: *Stakeholder Engagement*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Tribal Consultation	The SIM Office will take part in at least one official tribal consultation and determine a mutually agreed-upon plan for engaging with tribes thereafter.	None (SIM Office Staff)	Practice Transformation, HIT, Population Health, Payment Reform	SIM Office has participated in a tribal consultation with CDPHE/HCPF/CDHS by January 1, 2016. By March 1, 2016, the SIM Office has worked with tribes to outline an agreed-upon plan for future engagement of tribal entities
Public Comment Log	The SIM Office will create and update a log of all public comment received during public meetings and via the SIM website	None (SIM Office Staff)	Practice Transformation, HIT, Population Health, Payment Reform	Log is created by January 1, 2016 and updated at least once a quarter thereafter
Consumer Engagement Log	The Consumer Engagement Program director will track progress made toward incorporating identified Consumer Engagement priorities in SIM work	None (SIM Office Staff)	Practice Transformation, HIT, Population Health, Payment Reform	Log is kept up every quarter
SIM Outreach Tour	SIM Staff conduct community outreach and engagement outside of the Denver Metro Area	None (SIM Office Staff)	Practice Transformation, HIT, Population Health, Payment Reform	At least five presentations/meetings held outside of the Denver Metro area during each year of the grant

Plan for Improving Population Health

State Health Needs Assessment and Priority Setting

Leveraging Population Health Assessments

Named for its red soil, Colorado is a geographical landscape of mountains, plains, valleys, canyons, lakes, farmland and sand dunes. Colorado ranks eighth in the nation in geographic size with nearly 104,000 square miles of land ranging in elevation from 3,315 to 14,433 feet. The state hosts 54 mountain peaks over 14,000 feet high and more than a thousand peaks over 10,000 feet high.

As of 2015, there are 5.44 million people living in Colorado's 64 counties and two tribal nations. Approximately 85 percent of the population is concentrated on 20 percent of the state's land, primarily in the 200-mile stretch of land along the eastern side of the Rocky Mountains known as the Front Range. The remaining 15 percent of the population is spread across the state's 24 rural and 23 frontier communities. In fact, only 21 of Colorado's 64 counties have populations greater than 25,000.[8] There are also several resort communities due to the large recreational draw of tourists to Colorado. These communities are located mostly on the Western Slope and have a small permanent resident population but experience seasonal influxes of both tourists and temporary resident workers.

Colorado is one of the fastest growing states in the nation, largely due to in-migration.[9] The population is increasingly older and the greatest population growth was in the 55 to 64 year old age range. Currently, 70 percent of Colorado's population is non-Hispanic white, 20.7 percent is Hispanic, 3.8 percent is Black and 2.8 percent is Asian American or Pacific Islander. The fastest population growth is among Asian/Pacific Islanders and Hispanic Coloradans. Nearly 10 percent of Coloradans were born in a foreign country. While this foreign-born population comes from all over the world, almost half come from Mexico. Nearly 17 percent of Coloradans ages five years or older speak a language other than English at home.[10]

[8] Colorado State Demographers Office. Population Totals for Colorado Counties. http://www.colorado.gov/cs/Satellite/DOLA-Main/CBON/1251593346867: Colorado Division of Local Government; 2012.
[9] U. S. Census Bureau. Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2012. Online 2013.
[10] United States Department of Commerce, United States Census Bureau. 2011 American Community Survey. Washington, D.C.

Colorado's diverse geographic and cultural landscape leads to a wide scope and diversity of health needs and related issues among its residents. Additionally, numerous mountain passes and low population density in areas of the state pose unique challenges for accessing health care and related services.

Colorado SIM aims to address these unique health care challenges and improve its population health through two primary vehicles – an improved public health system, and a transformed health care delivery system with integrated primary care and behavioral health services – that will work together to create an effective and sustainable community-based system. Based on the social determinants of health model, our plan leverages the work of public health to reinforce strides in our clinical health delivery system. Working together, the two systems will build a collaborative and outcomes-oriented model of primary care and public health integration that helps us reach our SIM goal, which is to improve the health of Coloradans by providing access to integrated physical and behavioral health care services in coordinated systems, with value-based payment structures, for 80 percent of Colorado residents by 2019.

Colorado SIM defines population health as the health of a population, including the distribution of health outcomes and disparities in the population.[11] The SIM plan to improve population health leverages and builds upon existing statewide efforts during the past five years. These include the following state-level health assessments and plans:

- The State of Health: Colorado's Commitment to Become the Healthiest State;
- Colorado's 2013 Health and Environmental Assessment;
- Shaping a State of Health: Colorado's Plan to Improve Public Health and the Environment, 2015-2019;
- Local Community Health Assessments and Public Health Improvement Plans;
- Colorado's Winnable Battles; and
- Colorado's Maternal and Child Health (MCH) 2016-2020 Needs Assessment.

[11] Adapted from definition of Population Health in Kindig D., Stoddart G. What is population health? *Am J Public Health*.2003:93(3):380-383

These efforts identified several similar priority areas such as obesity, mental health and substance abuse, and health care access and integration, emphasizing the need for Colorado SIM to focus on behavioral health integration.

The State of Health: Colorado's Commitment to Become the Healthiest State released in May 2013, is a blueprint to create a comprehensive and person-centered statewide system to address a broad range of health needs, deliver the best care at the best value and help Coloradans achieve the best health possible. The report reflects input from stakeholders, including health care providers, advocates, lawmakers, insurance companies, and foundations. Four focus areas were defined:

- Promote prevention and wellness: preventing obesity, supporting improved mental health and better oral health, reducing substance abuse, and encouraging wellness among state employees (includes three Colorado Winnable Battles);
- Expand coverage, access and capacity;
- Improve health system integration and quality; and
- Enhance value and strengthen sustainability.

Colorado's 2013 Health and Environmental Assessment is a broad overview of the factors influencing the health and environment of Coloradans. It presents data and information from a variety of sources and includes population demographics and population-wide health and environmental issues, including those disproportionately affecting specific subpopulations. It then identifies existing and emerging issues to inform the development of Colorado's 2015-2019 Public Health Improvement Plan (PHIP), titled *Shaping a State of Health*, and provides a baseline by which to monitor change.

Healthy Colorado: Shaping a State of Health is Colorado's five-year roadmap for improving public health and the environment. It aligns with existing local, state and national efforts to establish Colorado's plan for improving public health and the environment from 2015 through 2019. It provides evidence-based strategies and helps guide actions with the ultimate goal of making measurable and lasting improvements for Coloradans. With input from partners from diverse agencies and organizations, the state's public health system has identified priority areas for improvement, measurable objectives, targets for health outcomes, and recommendations for continuing to build public health infrastructure and capacity. The plan includes goals, strategies and objectives for each of the following:

- Flagship Priority: Healthy eating, active living, and obesity prevention (Colorado Winnable Battle);
- Flagship Priority: Mental health and substance abuse (Colorado Winnable Battle);
- Health care access and coverage;
- Marijuana;
- Colorado's other Winnable Battles;
- Public health infrastructure; and
- LPHAs led assessment, planning and community engagement efforts in their own communities, which also informed the development of *Shaping a State of Health* and this Colorado SIM ***Plan for Improving Population Health***.

Colorado's Winnable Battles are focus areas for which Colorado can make population-level progress in a relatively short period of time and provide a framework for progress across a broad set of public health goals. They were prioritized through a process led by the CDPHE, multiple state agencies, and community partners in 2011 and include: Obesity, Mental Health & Substance Abuse, Oral Health, Clean Water, Healthier Air, Unintended Pregnancy, Infectious Disease Prevention, Safe Food, Tobacco, and Injury Prevention.

Every five years, CDPHE's MCH program conducts a statewide needs assessment of the health and wellbeing of Colorado's women, children and youth. The goal of the needs assessment is to collect and examine data to inform the selection of priorities that will drive state and local public health work for the next five years with the overall aim of leading to a measurable improvement in the health of the MCH population. *The Colorado MCH 2016-2020 Needs Assessment* resulted in the following seven priorities:

- Women's mental health including pregnancy-related depression;
- Reducing disparities in infant mortality among the African-American population;
- Early childhood obesity prevention;
- Developmental screening and referral systems building;

- Youth systems building with a focus on bullying, youth suicide, and substance use prevention;
- Medical home for children and youth with special health care needs; and
- Substance use/abuse prevention among the MCH population including marijuana, prescription drug abuse, alcohol, and smoking.

Additionally, we have considered and incorporated national assessments including Healthy People 2020 Leading Health Indicators[12] (HP2020 LHI) topics CDC Winnable Battles[13]. The HP2020 LHI are a set of high-priority health issues and actions organized into 26 indicators within 12 topic areas and include: access to health services, clinical preventive services, environmental quality, injury and violence, maternal, infant, and child health, mental health, nutrition, physical activity and obesity, oral health, reproductive and sexual health, social determinants, substance abuse, and tobacco. The CDC's Winnable Battles were chosen based on magnitude and feasibility and align and overlap with Colorado's own winnable battles. They are tobacco, nutrition, physical activity and obesity, food safety, health care-associated infections, motor vehicle injuries, teen pregnancy, and HIV in the U.S.

These local, state and national assessments and plans illustrate the current landscape of Colorado's population health assessment, prioritization, and planning and highlight collaborative approaches to address our population's healthcare needs. The table below demonstrates the opportunity to leverage and synergize the existing plans and resources to capitalize, maximize, and accomplish the population health goals of Colorado SIM. The priorities of the 53 LPHAs that completed community needs assessments and prioritization planning are included in the first column. This table does not show all priorities for each category, it only reflects those in common with at least one other source. Priority wording may differ from source.

[12] Office of Disease Prevention and Health Promotion: HealthyPeople.gov. Leading Health Indicators. http://www.healthypeople.gov/2020/Leading-Health-Indicators. Last updated and accessed on November 13, 2015.
[13] CDC and Prevention: Winnable Battles. http://www.cdc.gov/winnablebattles/. Last updated March 17, 2015. Accessed April 16, 2015.

Alignment of local, state and national priorities

	Local Priority - Frequency	Shaping a State of Health	CO Winnable Battle	CO MCH Priority	CDC Winnable Battle	HP 2020 LHI* Topic
Obesity	43	Flagship				
Mental Health	27	Flagship				
Substance Abuse	22	Flagship				
Clean Water	14					
Safe Food	13					
Clean Air	12					
Access to/Quality of Care	11					
Unintended Pregnancy	8					
Oral Health	6					
Injury Prevention	5					
Tobacco	5					
Infectious Disease	1					
MCH	1					

*HP=Healthy People, LHI=Leading Health Indicator

Resources to Determine Areas of High Burden and Cost

Three in 10, or 1.5 million, Coloradans are in need of mental health or SUD care, and nearly 1 in 12, or 450,000, people have a severe need. When care is provided, youths and adults of color are often disproportionately provided care in public human services settings, such as child welfare, juvenile justice, and corrections.[14] Colorado has the seventh highest suicide rate in the nation, and suicide is the second leading cause of death for Coloradans age 10-44 years old. In 2014 there were 1,058 suicide deaths in Colorado, which the highest ever recorded rate, and is more than other causes of mortality such as motor vehicle crashes, homicide, breast cancer, or diabetes.[15] As of 2012, the adult binge-

[14] The Mental Health Funders Collaborative. The Status of Behavioral Health in Colorado: Advancing Colorado's Mental Health Care. http://www.caap.us/pages/documents/2011StatusofHealthCareColoradoReport.pdf . 2011.
[15] CDPHE. Office of Suicide Prevention Annual Report: Suicide Prevention in Colorado 2015-2015. https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_OSP-2014-2015-Legislative-Report.pdf. November 1, 2015.

drinking rate was 19.2 percent, which is higher than the national average of 16.9 percent.[16] In addition, as of 2011 the drug poisoning death rate was 16.1 per 100,000 which is also higher than the national rate of 13.2 per 100,000.[17] Colorado now ranks as the 12th worst among all states for prescription drug misuse.[18] Finally, 27 LPHAs prioritized mental health and 22 prioritized substance abuse issues as a pressing public health need in their communities (see Table 1 above and ***Appendix B***).

About 1 in 10 Coloradans report having eight or more days of poor mental health within the last 30 days,[19] but many individuals in Colorado are unable to access the behavioral health services they need. The number of mental health and SUD providers in Colorado has increased in recent years; however there remains a workforce shortage of too few providers with specialized skills to serve those with the most complex behavioral health needs. The greatest need for providers is in rural and frontier areas of the state. Eighty-two percent of practicing psychiatrists, 86 percent of child psychiatrists, and almost all psychiatrists specializing in SUD treatment are located in the Denver and Colorado Springs metro areas.[20] Additionally, more than a third (22 of 64) of the counties in Colorado have zero licensed psychologists.[21] The table in ***Appendix B*** shows the percentage of Coloradans who did not receive needed mental health care for various reasons in 2013 and 2015.

Colorado residents with complex behavioral health care needs often access services through multiple systems. This increases health and human services costs and often results in ineffective, uncoordinated care. For instance, health spending for those with Medicaid coverage who accessed five or more state-funded programs in 2010 was more than $30,000 per person, which totals nearly 10 times the cost of the typical Medicaid medical claim.[22] Considering there are more than 1.3 million Coloradans on Medicaid, this adds up to a substantial and preventable cost. The spending of public mental health care in Colorado rose from 2002 to 2009, increasing from $62 per capita to $84 per capita, and $1,664 per

[16] CDC and Prevention: Sortable Risk Factors and Health Indicators. http://sortablestats.cdc.gov/#/summary. 2012. Accessed November, 13 2015.
[17] CDC and Prevention: Sortable Risk Factors and Health Indicators. http://sortablestats.cdc.gov/#/summary. 2011. Accessed November, 13 2015.
[18] Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health: State Estimates of Nonmedical Use of Prescription Pain Relievers. http://www.samhsa.gov/data/sites/default/files/NSDUH115/NSDUH115/sr115-nonmedical-use-pain-relievers.htm. January 8, 2013.
[19] Colorado Health Institute. Colorado Health Access Survey. http://www.coloradohealthinstitute.org/uploads/downloads/2015_CHAS_for_Web_.pdf. September 2015.
[20] The Mental Health Funders Collaborative. The Status of Behavioral Health in Colorado: Advancing Colorado's Mental Health Care. http://www.caap.us/pages/documents/2011StatusofHealthCareColoradoReport.pdf . 2011.
[21] Colorado Health Institute
[22] The Mental Health Funders Collaborative. The Status of Behavioral Health in Colorado: Advancing Colorado's Mental Health Care. http://www.caap.us/pages/documents/2011StatusofHealthCareColoradoReport.pdf . 2011.

person to $2,256 per person. Additionally, individuals with chronic physical health conditions and mental illness cost Medicaid 75 percent more than people without a mental illness.[23] One estimate gauged the cost for behavioral health needs in the Colorado criminal justice system in 2010 at more than $93 million.[24] Finally, in 2011, the age-adjusted rate of emergency department visits for a mental health diagnosis was 5,990.3 per 100,000 and the age-adjusted rate of hospitalizations with a mental health diagnosis was 2,912.2 per 100,000.[25] As such, social and emotional wellbeing, mental health, and substance abuse prevention have repeatedly arisen as current priorities for Colorado at the state and local level.

Mental and emotional wellbeing is essential to the health and wellness of Coloradans. Positive mental health allows people to realize their full potential, cope with the stresses of life, work productively, and make meaningful contributions to their communities. The public health role in behavioral health is rooted in the understanding that mental health is critical to overall health and should be prioritized as such. Behavioral health is a term inclusive of both mental health and substance abuse disorders, as well as health behavior change. Obesity treatment and prevention fall under behavior change interventions, and research indicates there is a relationship between obesity and depression. Increasing understanding about the complex intersections between these health issues is an important role for public health. Substance abuse is defined as overindulgence in or dependence on addictive substances, such as alcohol and illicit or prescription drugs, and is often associated with mental health status. It is a preventable health issue that has been linked to increased rates of sexually transmitted infections, domestic violence and child abuse, car crashes, crime, and suicide. Substance abuse is more common among people with SMI, and chronic drug use can exacerbate existing mental health disorders. The integrated medical home model has great potential for meeting the complex needs of patients with SMI and/or SUDs, and thereby reducing healthcare costs. The promotion of mental well-being, and the early identification and treatment of behavioral health disorders to prevent the debilitating effects of mental illness and substance abuse are population health strategies within the purview of public health.

Colorado's statewide priorities and initiatives relating to the goals of SIM have been established through the assessments and plans previously described. Broadly speaking, they include reducing substance

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[23] Boyd C., Leff B., Weiss C., Wolff J., Hamblin A. and Martin L. Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations. Center for Health Care Strategies. 2010.
[24] The Mental Health Funders Collaborative. The Status of Behavioral Health in Colorado: Advancing Colorado's Mental Health Care. http://www.caap.us/pages/documents/2011StatusofHealthCareColoradoReport.pdf . 2011.
[25] CDPHE. Colorado Health and Environmental Assessment, 2013. https://www.colorado.gov/pacific/sites/default/files/OPP_2013-Colorado-Health-and-Environmental-Assessment_0.pdf

abuse (such as alcohol, prescription drugs, and smoking); suicide prevention; obesity treatment and prevention; mental health promotion; expansion of health care coverage, access and capacity; improvement of health system integration and quality; and the overall promotion of prevention and wellness. Addressing these important and pressing behavioral health care needs will take a strategic approach of incorporating systematic, coordinated interventions at various levels of care. Utilizing the CDC framework, these levels of care are broken down as follows:

- Traditional clinical approaches;
- Innovative patient-centered care and funding models and/or clinical community linkages; and
- Community-wide approaches.

The traditional clinical level encompasses increasing the use of preventive care and screening activities in traditional health care settings such as clinics and hospitals and is typically performed by clinical providers. These are usually covered by insurers, but may not be sufficiently incentivized to maximize their utilization. Public health plays a role in supporting interventions within traditional clinical approaches by, for example, providing data and technical assistance to increase screening rates. Examples of interventions at this level include annual influenza vaccinations, use of aspirin for those at increased risk of a cardiovascular event, and screening for substance abuse.

The innovative patient-centered care and funding models and/or community-clinical linkages level include those approaches that are innovative, evidence-based strategies offered within the community that are not typically leveraged by health care systems currently operating in fee-for-service payment models. Instead innovations are focused on value based payment and include integrating clinical and community resources. Interventions at this level are typically not reimbursed in the traditional payment model. Specific examples include embedding patient navigators (PNs) as part of the care team to reduce barriers to care and producing health education to promote health literacy and patient self-management.

Finally, the community-wide level focuses on community factors that impact the health of a population. It includes system-wide action steps demonstrating an investment in total population health. It is not focused on clinically driven care, and instead looks at conditions that impact a patient's life, and therefore, their health. Some examples of these interventions include funding chronic disease self-management groups, passing policies related to tobacco control, and providing mental health stigma reduction campaigns. Colorado SIM will work to address our needs by intervening at all three levels of care and we have organized this plan based on this framework. It is important to note that although an

initiative or organization was categorically placed in a level of impact, this does not necessarily mean it operates only at that level. Instead, most of the activities identified operate at one more than level. The activities are placed based on the bulk of their work or where their SIM-related work best fit.

Existing Capacity and Efforts Aimed at Population Health

Activities and Capacity to be Leveraged

The various assessment and improvement plans discussed in section above are well underway in Colorado. In addition to these efforts being implemented in local, regional, and state settings, there are other funding and community-based opportunities available in the state outside of SIM to further leverage our SIM activities. It is clear that Colorado boasts local reforms and collaborative leadership approaches to health care systems change throughout the state. At the forefront of this movement are local communities taking the lead in innovation and implementation. This section highlights some of the work that is happening in Colorado that will help achieve Colorado SIM's goal based on the CDC's level of care approach, however this is not an exhaustive list of all of the transformational work that is happening in the state. Demonstrated below is not only the broad range of work that is happening to support health care transformation, but also the interconnectedness of partners and strategies from the local to the state level. There is momentum and buy-in in Colorado to achieve the SIM goal and ultimately, the Governor's goal, to become the healthiest state.

Traditional Clinical Level

The Colorado Primary Care Office (PCO) functions to lower the barriers that prevent Coloradans from receiving adequate primary, oral, and mental health care. The PCO works to address these barriers through assessing health profession shortage designations throughout the state and providing site designation and support on the part of the National Health Services Corps. The PCO is funded by the Health Resources and Services Administration (HRSA) to assist in the development of and delivery of comprehensive and quality health care services in areas with an identified shortage of health professionals.

In 2013, the Colorado Million Hearts Leadership Team developed a plan to reduce heart attacks and strokes in Colorado. The Team includes partners such as the American Heart Association, Kaiser Permanente Colorado, Colorado Prevention Center, Walgreens, LPHAs, CORHIO, Colorado Foundation for Medical Care, University of Colorado Skaggs School of Pharmacy, Regis University School of Pharmacy, the American College of Cardiologists, and other local stakeholders. The Team developed six

strategies focused on increasing awareness of hypertension and improving care and management of cardiovascular disease.

CDPHE's CDC-funded Clinical Quality Improvement for Population Health initiative supports implementation of evidence-based interventions for cancer and tobacco screening and chronic disease management among safety-net primary care health systems. This initiative engages with health systems to assess current performance on select health measures, increase capacity to monitor performance, identify public health focus areas, and implement targeted evidence-based interventions proven to improve health outcomes for the selected focus area. This project is currently working with 88 clinics serving at-risk and disparate populations in Colorado.

In March 2012, CDPHE invited the National Association of Chronic Disease Directors Policy State Technical Assistance Team (PSTAT) to provide training and skill development to address pre-diabetes-related policy issues. CDPHE organized a group of stakeholders, many of whom continue to participate in an advisory group to create and advance an action plan. This group includes Colorado Medicaid, CDHCPF health systems, the Governor's Office on Policy and Research, health plans, employers and community-based organizations. The PSTAT process resulted in the development of a five-year action plan for implementation by the members of the Colorado Advisory Group. The goals of this plan include achieving employer and health plan reimbursement for the Diabetes Prevention Program (DPP), increasing awareness and referrals to the DPP, and identifying and training appropriate community-based organizations to provide for the DPP. The CDC-funded Chronic Disease and School Health Grant has provided additional funding and resources to continue to work with health plans and employers to include DPP as a covered benefit.

Innovative Patient-Centered Care and Funding Models and/or Community Clinical Linkages

Funding Models

The ACC is Colorado Medicaid's primary health care program. It is designed to improve the patient experience and health outcomes while containing costs. The ACC program is operated by Colorado Medicaid. The first ACC clients were enrolled in May 2011, and as of August 2015 more than 940,000 of the 1.26 million total Medicaid enrollees were in the ACC. To date, the ACC has demonstrated cost- and system-efficiency results, including more than $29 million in net savings in state fiscal year 2013-14. The first five years of the program have created a platform for future reform efforts. The ACC is intended to

be an iterative program, driving a steady sustainable shift in the delivery system from one that incents volume to one that incents value.

Colorado is one of seven markets selected by CMS to participate in CPCI, a four-year, multi-payer initiative designed to test practice redesign models and a supportive multi-payer payment model. Under CPCI, CMS pays selected primary care practices a care management fee (initially set at an average of $20 per beneficiary per month) to support enhanced, coordinated services for Medicare beneficiaries in addition to fee-for-service payments. In 2015, CMS decreased the care management fee to $15 per beneficiary per month with the opportunity for shared savings for practices that can demonstrate decreased cost and improved quality of care. Simultaneously, participating commercial, state, and other federal insurance plans are offering enhanced payment to primary care practices designed to support them in providing high-quality primary care on behalf of their members.

In January 2014, Colorado Physician Health Partners (PHP) along with its strategic partner, Independent Practice Associations (IPAs), became one of 123 new Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program established by CMS. The goals of the Medicare Shared Saving Programs are to improve the patient care experience and outcomes while lowering associated costs. ACOs will continue to be evaluated by CMS on 33 quality performance measures in the areas of patient and caregiver experience of care, care coordination and patient safety, appropriate use of preventive health services, and improved care for at-risk populations. PHP and its participating providers will continue to collaborate with hospital systems, like-minded specialists, and community resources to achieve these goals. Any savings achieved through improving care coordination and providing appropriate, safe and timely care will be shared with Medicare.

Innovative Patient-Centered Care

CHES is a collaborative, multi-stakeholder organization that seeks to improve health and health care across Colorado through: 1) supporting redesign and innovation in primary care practices, improving their readiness for new payment models, and through practice transformation support and infrastructure development; 2) promoting local collaboration among health care providers, community groups, patient advisory groups, local public health officers, and public health agencies; and 3) facilitating local or regional efforts to improve health care to meet the Triple Aim of improving quality, improving experience of health care, and reducing costs.

ClinicNET provides a number of services to Community Safety Net Clinics in Colorado. From advocating for safety net issues to providing support services and educational resources, ClinicNET's services strengthen Colorado's health care safety net. ClinicNET provides coaching and assistance to enhance competencies that support practice transformation and innovative care delivery, including quality improvement coaching to help clinics address business operations and clinical inefficiencies, and identify best practices to reduce costs, improve clinical outcomes, and increase patient satisfaction. Lastly they focus on encouraging integrated best practice approaches to care delivery for physical, behavioral and oral health.

The Colorado Community Health network (CCHN) represents the 20 Colorado Community Health Centers (CHCs) that together are the backbone of the primary health care safety net in Colorado. The CCHN quality improvement team employs a method of practice facilitation whose goal is to make meaningful changes that will improve patient outcomes. CCHN utilizes practice facilitation methodologies that include conducting rapid plan-do-study-act cycles, documenting lessons learned, providing on-site and remote technical assistance, facilitating monthly check-in calls, and establishing learning communities through webinar series and learning forums.

Through the Technical Assistance Partners Grant with The Colorado Health Foundation, CCHN is working with safety net clinics to increase their capacity for team-based care. The primary focus of this initiative is to improve the delivery of health care, with empanelment, engaged leadership, and continuous quality improvement as the core objectives for the majority of participating clinics. CCHN is providing technical assistance to assist CHCs to develop standardized empanelment procedures, create plans for continuous quality assessment and improvement, and develop methodologies for addressing patient population needs.

The Colorado Rural Health Center (CRHC) is Colorado's nonprofit State Office of Rural Health. CRHC works with Federal, state, and local partners to offer services and resources to rural healthcare providers, facilities and communities. Serving more than 3,500 individuals and organizations, CRHC provides crucial resources, and opportunities to support providers in critical access and shortage areas.

In 2012, CDHS was awarded a System of Care Implementation Grant from the U.S. Department of Health and Human Services, SAMHSA. Colorado is one of 16 sites nationally to be awarded the grant, and will receive up to $1 million per year, for four years, to implement the system of care approach across the state.

CDPHE is one of 16 states that received a MCH Bureau-funded D70 implementation grant to improve the system of services for children and youth with special health care needs (CYSHCN) by developing and implementing a state plan. The overall objective of the plan is to increase the proportion of CYSHCN who receive integrated care through a patient/family-centered medical home approach by 20 percent by 2017. For Colorado, this specifically means an increase from 43.7 percent in 2009/10 to 52.4 percent in 2017. Required components of the state plan include: improving cross-systems care coordination, developing or enhancing a shared resource to meet the physical, oral, behavioral health and developmental needs of CYSHCN and their families, and improving integration of care across systems.

Clinical-Community Linkages

In 2015, the Colorado Office of Early Childhood at the CDHS developed a strategic plan for Early Childhood Mental Health aimed at ensuring all children and families are valued, socially and emotionally healthy, and their relationships are thriving. The plan includes the following three priorities: 1) a long-term sustainable financing approach exists for Colorado's early childhood mental health system, 2) coordination and alignment exists across systems that promotes and extends collaboration and integration, and 3) Colorado's early childhood workforce has the capacity and expertise defined through knowledge, skills, experiences, and the support necessary to promote child and family mental health and well-being.

Colorado Project LAUNCH (Linking Action for Unmet Needs in Children's Health) is a five-year cooperative agreement from SAMHSA to the state of Colorado and the Early Childhood Partnership of Adams County. Through Project LAUNCH, state and community partners aim to improve and coordinate young child-serving systems, as well as increase access to evidence-based, high-quality prevention/promotion services for children and families through five key strategies: 1) comprehensive screening and assessment in a range of child-serving settings, 2) integration of behavioral health into primary care, 3) early childhood mental health consultation in early care and education, 4) enhanced home visiting with a focus on social and emotional well-being, and 5) family strengthening and parent skills training.

Specific to integrated health and behavioral health, the local Project LAUNCH pilot community will implement strategies to increase screening and referral leading to successful follow-up by families, including care coordination and integrated behavioral health services with primary care clinics in south Adams County. Some of the policy and financing pieces that Project LAUNCH will be monitoring over the

course of the project are issues around reimbursement policies for screening (social emotional development and pregnancy-related depression) and care coordination, among others.

The Colorado Opportunity Project provides low-income Coloradans with economic opportunities for a pathway to middle class by middle age. The Project is based on the idea that opportunities (or obstacles) to reach the middle class are presented at each stage of life, from prenatal to adulthood. The Colorado Opportunity Project is a collaboration of CDHCPF, CDHS, and CDPHE. The Project will align key initiatives at the state agencies, like Winnable Battles, Two-Generation and the ACC, to drive all agencies towards a common goal of providing economic opportunity to Coloradans in a streamlined and efficient way. As of July 1, 2015, five Opportunity Liaisons were placed throughout the state to connect communities to their Regional Care Collaborative Organization.

In 2015, CDPHE launched the Patient Navigation Workforce Development Initiative, building off of six years of funding LPHAs and clinical and community partners to incorporate PN as part of the care team to reduce barriers to care. The goal of this initiative is to maximize the role of the PN by developing a program to credential PN education and training entities. A credentialed program for PNs will help by 1) aligning education and training programs around core competencies, 2) demonstrating to employers that the PN has graduated from a credentialed program and has achieved specific core competencies, 3) providing legitimacy of and clarity to the role of a PN to both the graduate of the program and the employer, 4) bringing clarity of the role to health team members, many of whom are clinicians and may not fully understand the potential benefit, 5) integrating the work of PNs within a health care team, allowing clinicians to focus on the services they are trained to provide and reducing the time spent on non-clinical tasks. This Workforce Development Initiative will ensure sustainability for this vital workforce that can help reduce disparities in our health care system.

Across the state, Colorado communities are establishing health alliances of health care leaders, providers, and community residents to work together to improve their community's health. Since mid-2012, the Colorado Coalition for the Medically Underserved (CCMU) has convened these alliances in a statewide learning network, called the Colorado Network of Health Alliances, which aims to increase the capacity, visibility, and efficiency of their collective work. These alliances strengthen local health systems through collaborative strategies, breaking down silos, and developing local leadership for change. Their unification may be based on geography, on a certain health issue, or on a specific population, but they all use similar strategies and collaborative leadership to pursue a common goal of increased access to care and improved population health. Since mid-2012, CCMU has convened these

diverse collaboratives through the Colorado Network of Health Alliances (The Network). The Network fosters strategic learning, networking, and collaboration between its members. In 2014, the Network grew to 28 members, representing over 73 percent of the counties in Colorado. The Network is rapidly becoming an unprecedented opportunity to support and facilitate local, collective responses to health systems reform in Colorado.

Community Wide Level

The Colorado Health Foundation is a nonprofit organization that engages through grant making, public policy and advocacy, private sector engagement, strategic communications, evaluation for learning and assessment, and by operating primary care residency training programs. They partner with nonprofits, health care leaders, policy makers, educators, and the private sector. The Colorado Health Foundation focuses on three community outcome areas of healthy living, health coverage and health care.

The Denver Foundation mobilizes resources to create a community where all residents of Metro Denver have the opportunity for a high quality of life, including in education, employment, food, clothing, shelter, health, cultural offerings, safety, and the ability to give of themselves and connect with their community. The Denver Foundation's Health Access Fund specifically supports programs and activities that increase access to health care and strive to improve health outcomes for populations in Colorado with high health care needs.

The Colorado Trust is a health foundation dedicated to ending inequalities that affect racial, ethnic, low-income, and other vulnerable populations, and believes everyone should have fair and equal opportunities to achieve good health. Its funding focus areas include community partnerships, health policy and advocacy, health data and information, health and well-being, and health equity investments.

In 2004, Colorado voters approved Amendment 35, a tax increase on cigarettes and other tobacco products. The additional revenue was designated for health care services and tobacco education to improve the health of all Coloradans. In 2015, the Colorado Board of Health approved funding recommendations for the Amendment 35 grant programs in fiscal years 2016-2018 and included the focus areas of cancer, cardiovascular and chronic pulmonary disease, health disparities, and tobacco education, prevention, and cessation. These dollars were distributed to community and public health organizations across the state to reduce disparities and prevalence of chronic disease.

Caring for Colorado is a grant-making foundation dedicated to improving the health and health care of the people of Colorado by improving health systems, focusing on population health and prevention, and

working to solve the most pressing health needs of vulnerable and underserved populations in the state. The foundation serves as a catalyst, building consensus and coalitions to create sustainable health system improvements through five funding priorities: 1) healthy children and youth, 2) health care workforce, 3) community health, 4) mental health, and 5) oral health. Specifically, Caring for Colorado is seeking to ensure access to high-quality integrated physical and behavioral health care, build the health care infrastructure and support services necessary to meet the physical, mental, and oral health of Colorado residents, and ensure Colorado has a high-quality and diverse healthcare workforce.

Each year Colorado receives Title V MCH Block Grant funding from the MCH Bureau of the U.S. HRSA for improving the health of mothers and children at state and local levels. LPHAs receive funding to implement strategies that align with the MCH priorities.

CDPHE's Nutrition Services Branch has developed nine research-based, Colorado audience-tested messages for health care providers, parents, and other caregivers on how to prevent childhood obesity, one child at a time. Messages cover breastfeeding, weight gain during pregnancy, healthy eating, TV viewing, physical activity, and more. The One Stop Early Childhood Obesity Prevention (ECOP) Shop 9 Ways to Grow Healthy Children offers a toolkit that includes posters, consumer handouts, and newsletter articles available for downloading, ordering, and sharing with partners. Webinars cover ECOP messages, maternal child health, and other early childhood obesity prevention topics.

CDPHE was awarded funding from the CDC for a five-year Essentials for Childhood: Safe, Stable, Nurturing Relationships and Environments project. It serves as the "backbone organization" of the project to coordinate cross-sector groups, guide vision and strategy, and support aligned activities. At the end of the project period, each of the five awarded states will serve as a case study to inform national standards to build safe, stable and nurturing relationships and environments. The project will collaborate with a wide variety of partners, both traditional and non-traditional, to promote the following agenda of advancing policy and community approaches to: increase family-friendly business practices across Colorado, increase access to childcare and after-school care, increase access to preschool and full-day kindergarten, and improve social and emotional health of mothers, fathers, caregivers, and children. Essentials for Childhood promotes the types of relationships and environments that help children grow up to be healthy and productive citizens so they can then build stronger and safer families and communities for their children, and targets change at systems, society and community levels.

Population Health Strategies and Activities under SIM

Colorado SIM designed its population health plan to align, leverage, and synergize with the multitude of other great population health efforts already occurring in the state. To complement and build upon these other efforts, this section outlines the Colorado SIM interventions, organized based on the CDC's three levels of care, that are both already occurring and planned to occur that seek to fill the remaining gaps in population health efforts working towards the integration of behavioral health into primary care. Mirroring SIM's efforts to leverage and align with the other population health activities occurring in the state, the activities described below are working together to align and leverage capacity within SIM. As demonstrated below, Colorado SIM is capitalizing off of the state's momentum and buy-in to achieve the SIM goal and ultimately the Governor's goal to become the healthiest state.

Traditional Clinical Approaches

CDPHE has been charged with developing and disseminating three courses targeted to enhance behavioral health delivery on the topics of pregnancy related depression, depression in men, and obesity and depression. These topics were chosen because of the demonstrated need of increased provider knowledge and skills in these areas. The first course is an online training module to present clinical guidance to providers regarding pregnancy related depression and has been released, though has not yet been broadly disseminated. CDPHE is currently planning to beta-test the online training with five to ten providers to ensure the training is easily accessible from the website, the educational curriculum is well received, and the pre-test/post-test infrastructure is working well prior to broad dissemination. The remaining two courses will also be online training opportunities presenting clinical guidance to providers and will be released in early 2016. All three courses are expected to reach a minimum of 100 providers each who practice in the fields of primary care, family practice, behavioral health, pediatrics, women's health, public health, and dietetics. In addition, the CDPHE is charged with developing a provider education and evaluation plan for years two through four of the SIM funding period that will be developed by the end of 2015. It will include descriptions of the providers that will receive the education, the type of education that will be provided, including the topics that will be covered, a description of the communication strategies CDPHE will use to communicate and disseminate the availability of the trainings, and an education evaluation plan that will include the methodology CDPHE will use to evaluate the effectiveness of all the training provided. CDPHE is working with other SIM funded entities, including the OBH and the University of Colorado School of Medicine, to align and leverage the opportunities available for providers and practices to support the integration of behavioral

health into primary care and other topics focused on health care transformation, including delivery reform and new payment models. This work will be sustained through existing partnerships with entities that prioritize provider education. Outside of Colorado SIM, CDPHE already partners with the University of Colorado and Project ECHO, where the SIM provider education modules will be stored, on other provider education projects. This partnership, which is dedicated to providing relevant, evidence-based, and up-to-date education, began prior to and will continue beyond the life of the SIM grant. Moreover, CPDHE will continue to fund education initiatives and programs as they relate to the priorities of the agency and the needs of Colorado's population, many of which align with the SIM vision of improving access to integrated behavioral and physical health care.

OBH will develop and disseminate an online SUD course to enhance integrated behavioral health starting in early 2016. It will be distributed to primary care providers and include information about SUDs, motivational interviewing techniques, opioid prescribing and treatment, and information about Colorado referral resources. Information and resources about pregnancy and substance use will be given to all providers involved in Colorado SIM, such as posters and materials regarding the Mother's Connection Campaign developed by OBH. State guidelines for psychotropic medications for children will be distributed to providers and practices will be connected to psychiatric consultation. In 2017, OBH will enhance and expand the work of SBIRT (short brief intervention, referral and treatment), which is a national model for behavioral health screening and referral, and increase the knowledge about the behavioral health needs of special populations. OBH will also develop an online course designed for senior behavioral health issues and intervention strategies that will be disseminated to 100 practices, and an educational course focused on behavioral health trauma and trauma-related issues to be disseminated to 50 practices in 2017. Finally, in 2018 OBH will develop a set of best practice guidelines for behavioral health staff working in health settings that will be based on national best practice information and developed with the SIM Workforce Committee. The guidelines will be disseminated at a symposium convened by OBH in late 2018. While the aforementioned resources and opportunities will be made available to all SIM-participating practices, OBH plans to leverage existing partnerships with the Children's Health Access Program, the Colorado Psychiatric Access & Consultation for Kids initiative, and Peer Assistance Services to ensure distribution of these opportunities to networks beyond SIM. OBH and the Colorado SIM office will continue to identify partners that can distribute the opportunities, ensuring that they are widely available and utilized.

Population health monitoring is a core component of SIM's Triple Aim framework and will provide the structure for monitoring and surveillance and inform the evaluation of Colorado SIM. CDPHE has developed Colorado SIM's behavioral health population health measure set. (Please see the table located in the ***Baseline and Accountability Targets*** subsection of the ***Core Progress Metrics and Accountability Targets*** section of the Operational Plan for a detailed outline of these measures.) These measures were selected systematically by inventorying existing Colorado population health measures that are currently tracked in reports and dashboards, and identifying gaps in population health data. Measures were selected that align with the SIM CQMs, provide information about the population burden of the health condition, and are timely, sustainable, and ideally available at both the state and county. Reflecting the innovative mission of Colorado SIM, CDPHE focused not only on traditional physical health measures, but also on behavioral health measures, which are not robustly monitored in our public health system. CDPHE successfully added depression-specific questions to the 2016 Behavioral Risk Factor Surveillance System questions set that will enable increased behavioral health tracking in Colorado. In the final inventory of population health metrics, there are 18 behavioral health measures and 16 physical health measures providing corollary population-level assessments to the SIM-required CQMs. The specific inputs for the inventory include the Behavioral Risk Factor Surveillance System, the Colorado Child Health Survey, the Healthy Kids Colorado Survey, the Pregnancy Risk Assessment Measurement Survey, the Prescription Drug Monitoring Program, the National Survey on Drug Use and Health, the Colorado Hospital Utilization Data, and Vital Statistics.

Innovative Patient-Centered Care and Funding Models and/or Community Clinical Linkages

The ACA authorized AHRQ to create a national Primary Care Extension Program (PCEP). This program deploys community-based Health Extension Agents to help providers "improve the accessibility, quality, and efficiency of primary care systems" and to "collaborate with local health departments … and other community agencies to identify community health priorities and … address the social and primary determinants of health."[26] Colorado SIM sees this model as a promising opportunity to create synergy between its two primary vehicles for improving population health – an improved public health system and a transformed healthcare delivery system with integrated primary care and behavioral health services. Initial efforts around health extension in Colorado indicate that the model is well positioned for success.

[26]Phillips, Robert. "The Primary Care Extension Program: A Catalyst for Change" *Annals of Family Medicine*. 2013; 11(2) 173-178

In 2010, the University of Colorado, Department of Family Medicine convened CHES with the goal of creating a statewide infrastructure to support and coordinate practice transformation and connect primary care, local public health, and other community organizations for community health improvement initiatives. In 2011, an AHRQ grant supported the CHES collaborative in joining a learning community across 18 states to test the health extension system model. The learning community resulting from this cooperative has given rise to the Colorado SIM Framework that will align both practice transformation and payment reform within SIM, but also across multiple other efforts. This alignment is crucial in providing a template for coordinated efforts to move practices, health care, and population health forward, at the same time bringing organization and order into the often chaotic context in which practices currently operate. A specific product that documents these efforts and the level of collaboration and cooperation among the organizations represented in CHES is the "Take Your Practice To the Next Level" catalogue of Colorado practice transformation projects, developed to assist practices in making carefully reasoned choices regarding projects that may assist them in moving forward with practice transformation. The catalogue explains the building blocks model used in the SIM Framework and provides an organized listing of practice transformation and quality improvement offerings from all Colorado practice transformation organizations that would help practices move forward in achieving the necessary advanced primary care competencies.

Largely due to the successes demonstrated across this learning community, Colorado SIM dedicated $5.5 million from December 2015 to January 2019 to deploy approximately 20 Health Extension Agents across the state. After hearing a presentation on the proposed plan for deployment, the SIM Advisory Board requested that Health Extension Agents in Colorado be renamed RHCs in order to avoid confusion with "Extension Agents" that continue to operate under the agricultural model in rural areas.

Colorado SIM is in the process of entering into an agreement with the Colorado Health Institute (CHI) to oversee deployment of the RHCs in partnership with CHES (pending approval from CMMI and HCPF procurement). CHI will be responsible for delivering on SIM contractual components related to extension services, while the CHES leadership and steering committee will be responsible for aligning the overall direction of health extension efforts across Colorado with our SIM project. CHI was selected to oversee this work due to its track record of success serving as the fiscal agent for major initiatives in Colorado, including the planning and building of CORHIO and the state's Health Insurance Exchange, as well as its unparalleled experience conducting research in local areas across the state related to behavioral health integration.

RHCs will facilitate linkages among the various components of communities and health care delivery systems, including primary care practices, Colorado's public health system, community-based organizations, state and regional agencies, and the academic system. RHCs will be housed at host agencies located in the communities served by the RHC throughout the state, giving them the flexibility to tailor their efforts to the unique needs in each of the communities they serve. However, delivering training and support for this new workforce through a centralized administrative agency (i.e., CHI) will create the conditions necessary to ensure success across all communities. This approach will meet the need to balance locally determined solutions with standardization across SIM efforts. Furthermore, because CHES is currently supporting deployment of six RHCs funded by AHRQ's EvidenceNow Southwest initiative, CHES leadership's continued collaboration with CHI will ensure that SIM-funded RHCs will complement, rather than duplicate, the work of those supported by AHRQ. (For additional information on EvidenceNow, please see the ***SIM Alignment with State and Federal Initiatives*** section of the Operational Plan.)

SIM extension activities are a significant component of the state's overall vision for the state's PCEP as originally developed by CHES. Colorado SIM, in conjunction with EvidenceNow, the Transforming Clinical Practices Initiative (TCPI), and the Colorado Health Foundation's investments in primary care practices, all support and advance the concepts and vision of CHES, which will continue to provide the strategy and guidance for this work. CHI will work with CHES to support a long-term business model that will establish CHES as the state's central extension service in the future.

The Colorado Health Access Fund of The Denver Foundation and the Colorado Department of Public Health and Environment SIM, jointly released a Request for Application (RFA) in September 2015. This cooperative RFA was a public-private partnership designed to eliminate overlap and redundancies and leverage funding opportunities in the state focused on behavioral health and wellness. This funding opportunity supports existing collaboratives that are already formally working together to meet shared goals around behavioral health. The collaboratives are to be comprised of community organizations and government agencies including LPHAs that have already come together across Colorado in a formal partnership of three or more unrelated organizations, resident groups, and/or public entities (such as behavioral health organizations). By working together in ways that make sense for their community, the organizations have the potential to bring assets and resources together in unique ways to increase access to behavioral health prevention and care and strive to improve behavioral health outcomes. The Denver Foundation will support projects related to increasing access to behavioral health treatment and

CDPHE SIM will support behavioral health prevention and screening. The goals of the treatment focused funding are to 1) reduce and remove barriers for Coloradans with high behavioral healthcare needs in accessing behavioral health care, 2) build on innovations and investments already in place around behavioral health care and support strategies for sustainability within the communities, 3) support solutions that will benefit and meet the needs of the local community, as well as explore how those solutions could be replicated and/or scaled to meet the needs of communities across the state, and; 4) widely share solutions and approaches that improve access to behavioral health care, as well as openly convey "lessons learned." The goals of the prevention focused funding include 1) behavioral health outreach and education focused on behavioral health wellness and prevention, 2) stigma reducing programs and campaigns, 3) community-based training and resources focused on behavioral health prevention, and 4) improved coordination of systems that improve behavioral health screening and referral, with a focus on assessment of community-based resources and gaps.

Community-Wide Approaches

CDPHE released an RFA in October 2015 for SIM funding to be distributed to LPHAs across the state to support activities that promote behavioral health and improve community based awareness, prevention, and screening of behavioral health disorders. Building upon the work that LPHAs began through their prioritization process, this funding opportunity will improve the health of Coloradans by building capacity and support for the implementation of behavioral health promotion and the prevention of behavioral health disorders. These activities will complement corresponding SIM activities to increase access to integrated physical and behavioral health care services in coordinated systems of care. The two focus areas that grantees must address are: 1) behavioral health promotion, outreach and education, and/or stigma reduction focused on evidence-based or research-informed behavioral health, wellness, and prevention strategies, and 2) coordination of systems that improve integration of behavioral health services and primary care, including an assessment of community-based resources and gaps in year one of the grant, accompanied by targeted and sustainable health systems interventions that improve screening, referral, and follow-up rates of U.S. Preventive Services Task Force A and B Recommendations in years two and three of the grant. It is expected that approximately 10 LPHAs will be funded for $100,000 per year for three years.

The SIM Population Health Workgroup is comprised of 17 individuals from community and governmental agencies across Colorado with subject matter expertise in population health. The workgroup convenes on a bi-monthly basis to provide expert input and feedback to ensure that SIM

interventions improve health outcomes at the community and population level and align and synergize with the other population health efforts occurring in Colorado. This workgroup will continue to provide input and work with the SIM evaluator to assess the population health impact of SIM funded initiatives at the community level.

Colorado SIM is committed to addressing the social determinants of health through encouraging and requiring our grantees, local public health agencies, to address health equity in their local communities. In Colorado, state and local-level community health assessments use Colorado's Health Equity Model as their guiding framework, resulting in health assessments and public health improvement plans that seek to address the social, economic, and environmental factors that impact individual and community health. CDPHE already tracks, monitors, and maps population health data and, depending on the population health measure, can break down this data by location, zip code, age, sex, income, and other demographic categories to better identify and understand issues related to social determinants of health. In December 2015, CDPHE met with SIM stakeholders to discuss how population health measures related to SIM can best be displayed in a publicly accessible dashboard. Ongoing meetings have been scheduled to discuss which demographic categories the data can be split into and how it can be presented in a way that highlights particular disparities. CDPHE and Colorado SIM will encourage Regional Health Connectors, funded LPHAS, and SIM Practices to use the dashboard to focus and guide their efforts. A prototype of the dashboard is anticipated in the first half of 2016.

Additional Opportunities under SIM

The SIM funding opportunities for population health collaboratives and LPHAs outlined above provide awardees with the opportunity to select the evidence-based or research-informed strategies that best address the unique needs of their community. As awardees work in conjunction with the SIM Evaluator, the Colorado SIM Office anticipates that certain promising practices that were not initially reflected in the original Colorado SIM Narrative will be identified at the community level. These practices will be analyzed for the potential to "scale up" to other areas of the state, and those that are most successful may be supported for broader implementation by the SIM Office. This approach supports the "test" focus of the Model Test Award, by working in conjunction with local communities to try new strategies, evaluating their impact, and scaling up as necessary.

Furthermore, Colorado SIM endeavors to consistently seek new partnerships and leverage emerging opportunities that may advance the SIM goal. In particular, the Colorado SIM Office is considering the following:

Innovative Patient-Centered Care and Community Linkages

While enrollment in health coverage is not a direct focus of SIM, the Colorado SIM office recognizes that success depends largely on Coloradans' ability to enroll in affordable coverage. According to the Colorado Health Access Survey, in 2015 approximately 353,000 Coloradans, or 6.7 percent of the state's population, remained without health insurance coverage.[27] Because mental health and SUD services, including behavioral health treatment, counseling, and psychotherapy, must be covered as one of ten essential health benefits for all insurance plans, access to coverage is directly related to access to care. As a result, Colorado SIM is seeking ways in which it can partner with Connect for Health Colorado, the state's insurance marketplace, and Colorado Medicaid to direct uninsured clients to Assistance Sites that provide free support in enrolling in public and subsidized insurance plans. Information about locating Assistance Sites may be included in the Implementation Guide and Resource Toolboxes developed by the University to support practice transformation efforts in SIM primary care practices. Furthermore, the RHCs discussed above may be encouraged to connect providers in their communities with agencies that offer free enrollment assistance. When developing communications regarding the value proposition of integrated care for patients, information on how to locate assistance in affordable coverage may also be provided.

Community-Wide Approaches

Several SIM stakeholders, including members of the Population Health Workgroup who were surveyed to provide feedback on additional opportunities, have expressed the need for greater emphasis on providing integrated care to criminal justice involved populations. While serving this population was briefly mentioned in the SIM Narrative, Colorado SIM has yet to identify a clear plan for doing so. The Colorado SIM Office requested technical assistance regarding barriers to accessing care faced by residents of community corrections (commonly referred to as "half-way houses"), with a particular focus on legislative barriers that prevent residents from enrolling in health coverage. The Colorado SIM Office is continuing to research this issue and will identify possible policy levers and public health approaches

[27] Colorado Health Institute. Colorado Health Access Survey. http://www.coloradohealthinstitute.org/uploads/downloads/2015_CHAS_for_Web_.pdf. September 2015.

that can be used to ensure that this population is able to access integrated care. In particular, Colorado SIM is considering how it can support Colorado's Community Living Plan, which was developed by state agency representatives and stakeholder groups with the following four goals in mind: 1) support transition to community settings, 2) ensure living in a stable, dignified and productive manner, 3) prevent initial entry or re-entry into institutional setting, and 4) ensure achievement of outcomes through transparent oversight and evaluation efforts.

Roadmap to Improve Population Health

Colorado's current population health activities summarized in sections A and B provide a platform to leverage health care system strategies and broader public health goals and community efforts to improve the health of the state's population. Colorado's strategic behavioral health population health road map (Section D) represents the work that is being done in Colorado that impacts the behavioral health and wellness of the population. It is well established that the behavioral health of a population impacts the overall health of the population. For this reason our road map is a focused inventory of the behavioral health strategies that align with or support the SIM goal and represent the opportunities to support Colorado's health delivery system and behavioral health integration efforts. These approaches are categorized into the three previously described levels of care including the traditional clinical, innovative patient-centered care and funding models and/or community linkages, and community-wide approaches.

Broadly speaking, Colorado SIM focuses on the integration of behavioral health and physical health. This roadmap represents a drill-down into the various behavioral health priorities, strategies and work that has been developed across the state of Colorado and are identified as efforts to be leveraged and considered in order for Colorado SIM to achieve its goal. The inputs of this roadmap include Shaping a State of Health: Colorado's Plan to Improve Public Health and the Environment, 2015-2019, Colorado's MCH 2016-2020 Needs Assessment, and The State of Health: Colorado's Commitment to Become the Healthiest State, and are selected based upon their applicability to SIM and their potential reach. The list is not exhaustive, but is representative of Colorado's behavioral health population health work as it relates to Colorado SIM. Specifically, the behavioral health population health roadmap is organized based on priority area, and identifies proposed strategies and approaches to meet this goal, along with the proposed indicators and metrics to track impact. Each strategy is classified into one of the three identified levels of care. Finally, Colorado SIM priority areas and the associated strategies and metrics

identified are presented in the table to demonstrate the alignment of Colorado SIM with the other population health efforts already in place.

This roadmap serves as a guide for Colorado SIM's activities for the next three years. The identified SIM goals, activities, and measures will be a part of the population health evaluation and contribute to the broader Colorado SIM evaluation. The SIM goals and associated strategies and metrics will continuously be evaluated for progress and effectiveness, and collaboration with partners will continue to ensure aligned efforts surrounding the Colorado SIM goals, strategies, and measures. Moreover, the roadmap will allow for monitoring of the other population health efforts occurring in the state that relate to Colorado SIM, and tracking off these efforts will continue for the duration of SIM. The Colorado SIM identified metrics and indicators will be tracked by CDPHE staff and reported to the Colorado SIM Office on a biannual basis.

Colorado has made great strides in its population health efforts, and Colorado SIM has made great progress in building a behavioral health integration and health systems delivery infrastructure. Over the next three years, continued SIM funding will allow the targeted integration of physical and behavioral health in more than 400 primary care practices and CMHCs with about 1,600 primary care providers, bring the majority of payers into shared risk and savings programs by 2019, expand information technology efforts, including telehealth, and launch a robust evaluation program that measures both processes and outcomes. The population health efforts of Colorado SIM are poised and ready to help Colorado SIM achieve its goal of improving the health of Coloradans by providing access to integrated primary care and behavioral health services in coordinated community systems, with value-based payment structures, for 80 percent of the state's residents by 2019.

Behavioral Health Population Health Roadmap

KEY	
MCH	Colorado Maternal and Child Health 2016-2020 Needs Assessment
State of Health	The State of Health: Colorado's Commitment to Become the Healthiest State
State PHIP	Shaping a State of Health: Colorado's Plan to Improve Public Health and the Environment, 2015-2019
SIM	Colorado SIM

Goals	Proposed Approach/Strategy	Proposed Metric/Indicator	Source	Level of Impact
Priority Area: Behavioral and Mental Health				
1. Advance policy and community approaches to improve the social and emotional health of mothers, fathers, caregivers, and children	Expand comprehensive social and emotional health screening of caregivers by increasing adoption of depression screening codes for caregivers at the child's visit	TBD	State PHIP	Traditional clinical approaches
	Support efforts designed to increase access to high quality mental and behavioral health care	TBD	State PHIP	Traditional clinical approaches
	Develop and expand the behavioral health workforce	TBD	State PHIP	Traditional clinical approaches
	Change the reimbursement structure for mental health services by increasing incentives	TBD	State PHIP	Traditional clinical approaches
	Promote best practice mental health integration in all publicly funded primary care	TBD	State PHIP	Innovative patient-centered care and/or community linkages
2. Increase the number of children in Colorado receiving age-appropriate developmental screening and increase the number of children who are evaluated and who receive services	Identify and implement policy/systems changes that improve developmental screening, referral and services for children ages 10 through 71 months	# of state agency leaders and statewide partners who develop and endorse key recommendations for improved policies and coordination of services related to developmental screening, referral, and intervention services	MCH	Innovative patient-centered care and/or community linkages

among those with identified needs		# of statewide organizations or systems that implement developmental screening, referral and intervention recommendations	MCH	Innovative patient-centered care and/or community linkages
	Support individualized technical assistance to LPHAs, community and health care partners on best practices in early childhood developmental screening, referral and interventions services	# of LPHAs, community and/or health care partners in Colorado that have implemented internal processes that support optimal early childhood development through a family centered approach	MCH	Innovative patient-centered care and/or community linkages
3. Reduce the burden of depression in Colorado, especially among pregnant women, men of working age, and individuals who are obese	Improve screening and referral practices	Percent of adults who reported taking medication or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem	State PHIP	Traditional clinical approaches
	Reduce stigma of seeking help for depression	Percent of adults who report experiencing symptoms of depression (increase implies reduced stigma)	State PHIP	Community-wide strategies
	Partner with stakeholders and the Governor's office to share consistent messages focused on mental health as a part of overall health, and the importance of integrated care delivery systems	Number of partnerships sharing consistent messaging focused on mental health as a part of overall health, and the importance of integrated care delivery systems	State PHIP	Community-wide strategies
3a. Reduce the burden of depression among pregnant and postpartum women	Develop competencies for providers and hospitals to more adequately address pregnancy related depression (PRD)	% of mothers reporting that a doctor, nurse or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery	State PHIP	Traditional clinical approaches
		% of mothers who are appropriately screened and treated for depression	State PHIP	Traditional clinical approaches
		# of providers and/or hospitals in Colorado that implement key PRD competencies into standard work	MCH	Traditional clinical approaches
	Strengthen referral networks for providers to address pregnancy-related depression	# of pregnant and postpartum women with PRD symptoms referred for treatment	MCH	Innovative patient-centered care and/or community linkages

		# of Medicaid providers who screen pregnant or postpartum women for PRD	MCH	Innovative patient-centered care and/or community linkages
		% of providers who talk to a woman about what to do if they experience signs and symptoms of depression	MCH	Innovative patient-centered care and/or community linkages
	Develop and implement a public awareness initiative to address stigma	% of pregnant and postpartum women who understand that PRD is common and that it is okay to ask for help	MCH	Community-wide strategies
3b. Reduce the burden of depression among men of working age	Reduce the stigma of seeking help for depression	# of men who access and use Mind Master, the online cognitive behavior therapy tool on Mantherapy.org	State PHIP	Innovative patient-centered care and/or community linkages
	Increase access to an online cognitive behavior therapy tool through access to the Man Therapy campaign and website	Percent of men who report experiencing symptoms of depression (an increase implies reduction in stigma)	State PHIP	Community-wide strategies
		Number of visitors to Mantherapy.org	State PHIP	Community-wide strategies
3c. Reduce the burden of depression among individuals who are obese	Provide best practices, tools, and guidelines to primary care and behavioral health providers on screening and referral for depression and physical health care needs for obese patients	# of viewers of online training about the relationship between depression and obesity that describes best practices and tools to improve screening and referral for depression and physical health care needs for obese patients	State PHIP	Traditional clinical approaches
Priority Area: Substance Abuse				
1. Reduce prescription drug overdose death rates of Coloradans ages 15 and older 2. Decrease the percent of women ages 18-44 who used an illicit drug (including marijuana or non-medical use of prescription drugs) during the past 30 days	Improve usability and appropriate accessibility of the prescription drug monitoring program (PDMP) system through the use of information technology, increased stakeholder access, and increase use as a public health tool	Ratio of queries of the prescription drug monitoring program database per filled controlled substance prescription	State PHIP	Innovative patient-centered care and/or community linkages
		Ratio of queries to PDMP per high-dose opioid prescriptions dispensed to women age 18-44	MCH	Innovative patient centered care and/or community linkages
	Ensure all physicians and dentists receive continuing education about safe prescribing practices, including the use of the PDMP	Rule(s) promulgated for all DORA-licensed prescribers to include pain management guidelines and	State PHIP	Traditional clinical approaches

		require continuing education on safe prescribing practices		
		Statement issued to physicians by the Colorado State Board of Health, Board of Medicine, Department of Regulatory Affairs, or other statewide medical recommending body (e.g. CO AAP) regarding medical marijuana use during pregnancy or post-partum	MCH	Traditional clinical approaches
		# of partners enlisted to offer provider trainings regarding safe and effective pain management practices, including the use of the PDMP	State PHIP	Traditional clinical approaches
		# of health care providers who provide care to pregnant, post-partum, or women of reproductive age that complete prescription drug continuing medical education training or that receive marijuana education	MCH	Traditional clinical approaches
	Increase access to permanent disposal sites for controlled substances	# of permanent drug disposal sites for controlled substances	State PHIP & MCH	Community-wide strategies
	Work with partners to inform and disseminate mass reach health education campaigns that target pregnant and post-partum women with substance abuse prevention messages	Perception of "no risk" of harm from daily or near daily use of marijuana among women ages 18-44, and specifically for pregnant and postpartum women	MCH	Community-wide strategies
Priority Area: Health Care Access, Coverage, Integration and Quality				
1. Align state and local public health with health care reform efforts to increase	Standardize and connect public health data systems to allow for appropriate electronic public health and clinical	Number of sites reporting successful ongoing submission of appropriate public health tracking data	State PHIP	Innovative patient-centered care and/or community linkages

access to and utilization of health care and related services	data exchange through the Health Information Exchange	Number of public health agencies able to engage in real-time data sharing with Health Information Exchange	State PHIP	Innovative patient-centered care and/or community linkages
	Increase collaboration among clinical care, public health and payers to build a more integrated, effective health care system	State plan for investment in workforce development for primary, oral and mental health providers who care for medically underserved Coloradans	State PHIP	Innovative patient-centered care and/or community linkages
			State PHIP	Innovative patient-centered care and/or community linkages
	Develop policy and systems change strategies that support a medical home approach within their communities	% of children ages 1-14 who receive care within a medical home	State PHIP	Innovative patient-centered care and/or community linkages
		% of children and youth with special health care needs (CYSHCN) ages 1-14 who receive care within a medical home	State PHIP	Innovative patient-centered care and/or community linkages
	Identify and implement policy/systems changes that support communication and collaboration between programs that provide care coordination for children and youth	% of CYSHCN who receive HCP Care Coordination services that have an inter-agency plan of care	MCH	Innovative patient-centered care and/or community linkages
	Identify and implement policy and systems changes that enhance statewide access to pediatric specialty care for CYSHCN	Development of an implementation and funding plan based on the key recommendations identified by the interagency pediatric specialty care partners	MCH	Innovative patient-centered care and/or community linkages
	Identify and implement policy and systems changes that strengthen transitions for CYSHCN	Identification and prioritization of evidence based transition strategies for state and local implementation to strengthen transition for CYSHCN	MCH	Innovative patient-centered care and/or community linkages
2. Expand health care access	Close gaps in access to primary care and other health services	# of new providers recruited and retained	State of Health	Traditional clinical approaches

3. Improve health care coverage	Expand public and private health insurance	# of Coloradans who are insured	State of Health	Community-wide strategies
4. Improve health system integration and quality	Expand use of patient-centered medical homes for Colorado adults	Number of Colorado adults connected to a patient-centered medical home	State of Health	Innovative patient-centered care and/or community linkages
	Support better behavioral health through integration	TBD	State of Health	Innovative patient-centered care and/or community linkages
5. Enhance value and strengthen sustainability	Reduce Medicaid costs by expanding and developing new care delivery platforms	ACC cost savings per year	State of Health	Innovative patient-centered care and/or community linkages
	Invest in HIT	# of Coloradans served by providers with EHRs and connected to Health Information Exchange	State of Health	Innovative patient-centered care and/or community linkages
	Advance payment reform in the public and private sectors	# of payment reform pathways in Colorado	State of Health	Innovative patient-centered care and/or community linkages
Priority Area: Healthy Eating, Active Living and Obesity Prevention				
1. Increase the percentage of infants who are ever breastfed, and exclusively	Develop and support policies and programs that protect, promote and	# of hospitals designated as Baby-Friendly	State PHIP, MCH,	Innovative patient-centered care and/or community linkages

breastfeed through six months	support breastfeeding-friendly environments		Vision 2018	
		Marketing and distribution of a toolkit of resources and training opportunities to strengthen breastfeeding support	MCH	Innovative patient-centered care and/or community linkages
2. Improve nutrition and physical activity environments for children younger than 18 years via early childhood education centers and schools, especially those that serve low-income populations	Implement cross-sector use among providers of consistent messaging related to early childhood obesity prevention (ECOP) evidence-based practices	# of partners reporting dissemination and/or use of ECOP messages in their practice, programs and activities	MCH	Traditional clinical approaches
	Expand access to the child and adult care food after-school program	# of meals distributed	State PHIP	Community-wide strategies
	Implement evidence-based physical activity interventions in select child care centers through a network of state and local partners	# of providers representing child care centers that have integrated structured physical activity into center lesson plans, curriculum and/or policy	MCH	Community-wide strategies
3. Increase access to worksite wellness programs and to healthy foods and beverages in worksite and government settings	Develop a statewide strategic plan for worksite wellness that includes a network to assess, implement, communicate, and deliver national best practices in worksite wellness	# of worksites that have adopted worksite wellness policies combining healthy eating, lactation accommodation, and physical activity	State PHIP	Innovative patient-centered care and/or community linkages
	Increase referrals to, use of, and reimbursement for the Diabetes Prevention Program	# of adults ages 18 and older with pre-diabetes and/or at high risk of developing type 2 diabetes enrolled in the Diabetes Prevention Program	State PHIP	Innovative patient-centered care and/or community linkages
4. Advance ‘health in all policies’ as a widespread philosophy for actively engaging in state and local land use, transportation, agriculture and community development initiatives	Develop policy and environmental strategies that focus on increasing access to physical activity and promoting health equity	# of local governments that have adopted and/or implemented policies and environmental strategies to increase safe, equitable access to physical activity through the built environment	State PHIP	Community-wide strategies

SIM-Specific Activities				
Goals	**Proposed Approach/Strategy**	**Proposed Metric/Indicator**	**Source**	**Level of Impact**
Priority Area: Behavioral and Mental Health				
1.Increase provider knowledge surrounding behavioral and mental health issues with emphasis on vulnerable populations	Develop provider education on pregnancy-related depression, obesity and depression, depression in men, senior behavioral health, and behavioral health trauma/trauma related issues	# of providers who complete the courses (evaluation plan to be determined)	SIM	Traditional clinical approaches
	Develop provider education and evaluation plan to outline the education and evaluation that will be delivered following the successful delivery of the first three modules	# of providers who complete the courses (evaluation plan to be determined)	SIM	Traditional clinical approaches
	Develop state guidelines for psychotropic medications for children and distribute to providers and practices, specifically emphasizing practices that serve foster care and welfare children	Document created and # of SIM practices reporting use of guidelines	SIM	Traditional clinical approaches
2. Improve behavioral health screening and referral	Enhance and expand the work of SBIRT and work to increase the knowledge about the behavioral health needs of special populations	# of sites implementing SBIRT	SIM	Traditional clinical approaches
3. Improve upon traditional public health surveillance to incorporate behavioral health measures	Develop an inventory of public health surveillance measures and identify physical and behavioral population health measures that align with the SIM CQMs and are available at the state and county levels	SIM population health measures inventory and tracking system created	SIM	Traditional clinical approaches
4. Increase LPHA capacity to support community-based behavioral health integration	Increase number of LPHAs who participate in a collaborative or coalition focused on behavioral health and wellness and prevention of chronic disease	# of LPHAs funded through SIM funding who participate in a collaborative or coalition with community partners	SIM	Innovative patient-centered care and/or community linkages

	Build capacity and support in LPHAs for the implementation of behavioral health promotion and the prevention of behavioral health disorders through technical assistance and learning collaboratives	Technical assistance provided (evaluation plan to be determined)	SIM	Community-wide strategies
	Distribute SIM funding to LPHAs to support activities that promote behavioral health and improve community based awareness, prevention and screening of behavioral health disorders	# of LPHAs funded (evaluation plan to be determined)	SIM	Community-wide strategies
Priority Area: Substance Abuse				
1. Increase provider knowledge surrounding SUDs	Develop and disseminate SUD education to enhance integrated behavioral health	# of providers who complete the courses and the number of courses offered	SIM	Traditional clinical approaches
	Develop and disseminate pregnancy and SUD education to enhance integrated behavioral health	# of providers who complete the courses and the number of courses offered	SIM	Traditional clinical approaches
Priority Area: Health Care Access, Coverage, Integration, and Quality				
1. Increase provider and clinic/hospital competencies about behavioral health and primary care integration	Develop best practice guidelines for behavioral health staff working in health settings	Guidelines created	SIM	Traditional clinical approaches
2. Increase community capacity to support behavioral health	Deploy Regional Health Connectors across the Colorado to facilitate linkages among the various components of the health and health care delivery system	# of Regional Health Connectors deployed	SIM	Innovative patient-centered care and/or community linkages
	Improve the accessibility, quality, and efficiency of primary care systems by collaborating with local health departments and other community agencies	# of partnerships formed	SIM	Innovative patient-centered care and/or community linkages

3. Strengthen community-based behavioral health collaboratives	Increase access to behavioral health care by funding projects that increase access to behavioral health prevention, screening and treatment	# of projects funded by SIM	SIM	Innovative patient-centered care and/or community linkages
	Fund existing collaboratives comprised of community organizations and government agencies including LPHAs in a formal partnership of three or more unrelated organizations to meet shared goals around behavioral health	# of collaboratives funded	SIM	Community-wide strategies

Health Care Delivery Transformation Plan

In order to achieve its goal of providing access to integrated physical and behavioral health care services in coordinated systems, with value-based payment structures, to 80 percent of Colorado residents by 2019, Colorado SIM will:

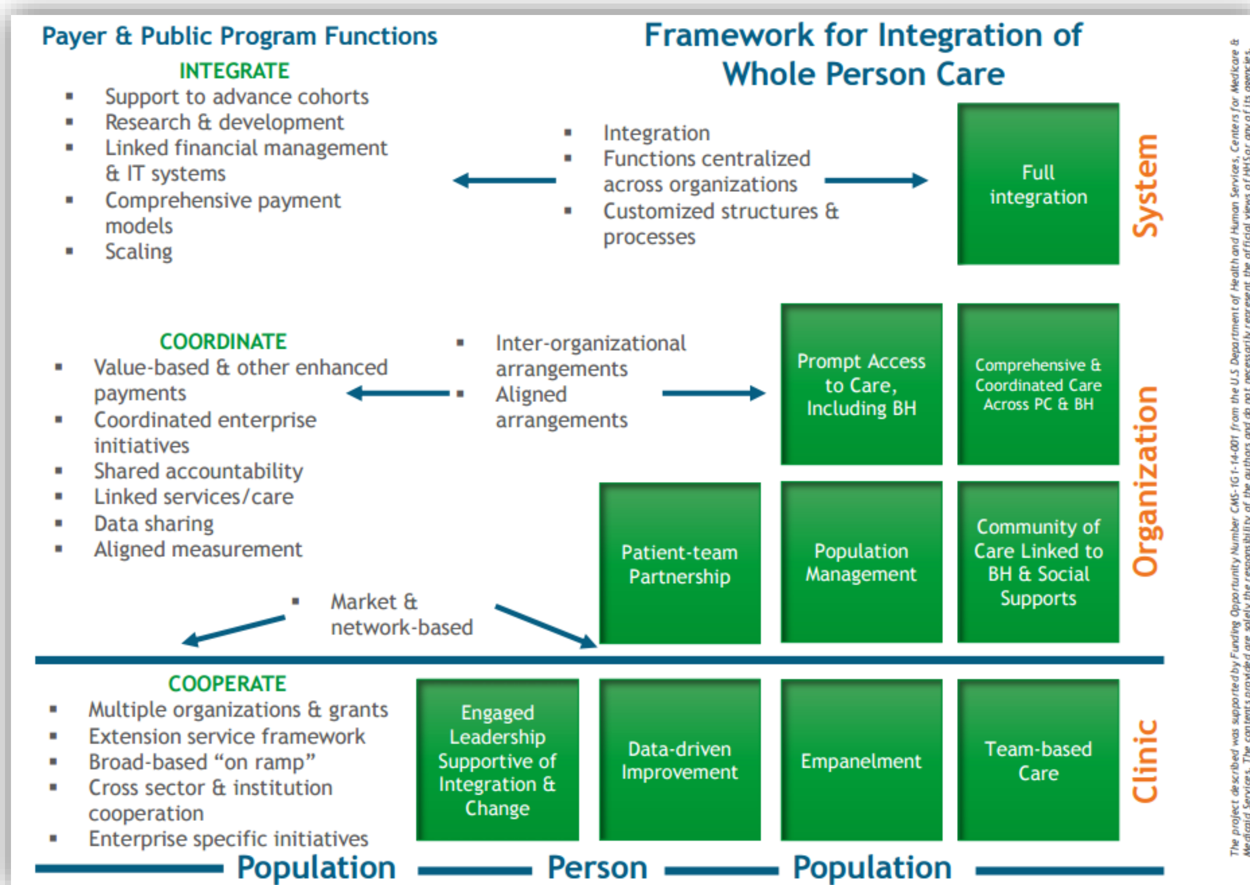
- Provide practice transformation support to approximately 400 primary care practices during the three-year grant implementation period; and
- Support a Bi-Directional Integration Demonstration Pilot that will create integrated health homes in four CMHCs.

The SIM Practice Transformation and Service Delivery Stakeholder Workgroup provides guidance on all aspects of practice transformation, working to provide thought leadership, promote synergy with payment reform efforts, and to assure alignment with other components of Colorado SIM.

Practice Transformation in the Primary Care Setting

Conceptual Framework

Primary care practices that participate in SIM Practice Transformation efforts will be provided with support to help them transition to care delivery models that integrate physical and behavioral health. In order to advance change, Colorado SIM has adopted a building block model based on Dr. Thomas Bodenheimer's conceptual framework on the "Building Blocks of High-Performing Primary Care." The framework includes: engaged leadership, data-driven improvement, patient empanelment, team-based care, patient and family engagement, population health, continuity of care, prompt access to care, comprehensive care management and care coordination and integration of primary care and behavioral health.



Practice transformation efforts are designed to assist practices at all levels of integration by targeting the building blocks in which they have the most room to improve.

Additionally, the activities outlined in the Practice Milestones (see ***Appendix C***) will be used to guide efforts in achieving the building blocks in this framework. A Practice Transformation Design committee, with input from over 40 subject-matter experts, selected the milestones, which were designed to align with CPCI milestones. The framework has since been adapted and approved by the SIM Payment Reform and Practice Transformation Workgroups as well as by the MPC.

Agreement with the University of Colorado

On July 1, 2015, the Colorado SIM Office entered into an interagency agreement with the University of Colorado (the University) to lead practice transformation efforts across the state. The University is establishing a multi-layered support mechanism for practices to use as they move further along the continuum of integrating behavioral health with primary care and adapt to new value-based payment models. The different layers of assistance include:

- Direct support provided by pre-qualified Practice Transformation Organizations (PTOs) that deliver customized practice facilitation and clinical HIT advisory services to address practice-specific needs;
- Additional consultation provided by subject matter experts to address specific needs in adapting to value-based payment models and other specialized integration challenges;
- Establishing and maintaining "toolboxes" of practice transformation models, templates, resources, and best practices; and
- Learning collaboratives to provide general information, share lessons learned, and disseminate best practices. This multi-layered approach provides the flexibility to meet individual practice needs through customized solutions while still being anchored in an overall process that focuses on achieving SIM objectives in a manner that maximizes accountability and cost-effectiveness.

Selection of SIM Practices

Three cohorts of primary care practices will be selected for inclusion in SIM practice transformation activities over a three-year period:

- **Cohort 1:** 100 practices beginning in February 2016; two years of practice transformation support;
- **Cohort 2:** 150 practices beginning in February 2017; two years of practice transformation support; and
- **Cohort 3:** 150 practices beginning in February 2018; one year of practice transformation support.

First Cohort of Practices

In September 2015, the University issued a competitive RFA for primary care practices in Colorado that wished to participate in the first SIM Practice Transformation Cohort.

Expectations for Participation

Expectations for practices that participate in SIM include:

- Forming a cross-functional SIM implementation team with representation from various roles within the practice. For most practices this team will include a primary care provider, office administrator, clinical support, and front-desk staff. Depending on the practice it may also include a behavioral health professional and/or a care manager;
- Allocating time for the SIM implementation team to meet with the practice facilitator approximately twice a month for approximately one hour each time;
- Allocating time as needed to work with a CHITA to assist with practice data reporting and review of a data quality plan;
- Collecting, reporting and reviewing measures. Practices participating in SIM will be required to have an EHR and must be able to submit a core set of measures on a quarterly basis. Practices will be encouraged to implement an automated quality reporting mechanism using discreet patient-level data elements currently under development by the SIM Office;
- Participating in two regional collaborative learning sessions annually. In a spirit of fostering a true peer-to-peer learning community, practice representatives may be asked to share insights through presentations and panel discussions at these sessions; and
- Participating in the evaluation process, which includes completing the baseline, interim and end of project assessments, periodic completion of the Practice Monitor survey and potentially key informant interviews with the evaluation organization with which SIM contracts. Other requirements may be specified by the evaluation organization.

Current State

One hundred ninety practices submitted applications for the first cohort. Of these practices, 179 met the criteria necessary to merit review. A panel of independent reviewers convened through the University reviewed all qualified applicants and classified them as “highly recommended,” “recommended,” “possibly ready for participation – with concerns,” and “not yet ready for participation.” The Colorado SIM Office considered the recommendations of the University review panel as well as a broad array of factors (including but not limited to geographic location, practice affiliation, practice type, and payer

support) and selected 100 practices to accept and 39 practices to waitlist, with the goal of selecting a cohort that reflected a high-degree of diversity. If a practice should choose not to participate, another practice will be selected off of the waitlist to take its place. Every effort will be made to maintain a balance between practice locations, sizes, types, payer support, and affiliation.

Next Steps

Payers will be provided with a list of practices who were accepted and will be reaching out to those practices that they agree to support with alternative payment models in January. By February 1, 2016 the University will establish practice participation agreements with selected practices that decide to participate in the SIM-supported transformation assistance activities.

Recruitment of Subsequent Cohorts

Selection criteria for subsequent cohorts will be refined to reflect lessons learned and to ensure the largest reach possible.

PTOs

In September 2015, the University selected 17 agencies to serve as PTOs through an open and competitive application process:

- Centura Health;
- ClinicNet, Inc.;
- Colorado Children's Healthcare Access Program;
- Colorado Community Health Network;
- Colorado Community Managed Care Network;
- Colorado Regional Health Information Organization;
- Colorado Rural Health Center;
- Community Health Partnership;
- Denver Health and Hospital Authority;
- HealthTeamWorks;
- High Plains Research Network;
- Physician Health Partners;
- Quality Health Network;
- Rocky Mountain HMO Inc.;
- Telligen, Inc.;

- UCHealth Plan Administrators, LLC; and
- University of Colorado College of Nursing.

PTOs will be responsible for providing either, or both, of the following supportive functions to assist in practice transformation:

- Practice facilitation to primary care practices to accomplish the goals and milestones set out for SIM; and
- CHITA support for practices to assist in reporting and using clean CQMs and other related data.

Essential Practice Facilitator Functions

In particular, practice facilitation functions will include assisting practices to achieve the Practice Transformation milestones through supporting them to:

- Engage with local public health and community health organizations;
- Improve access to and continuity of care;
- Offer self-management support, goal setting, and action planning with patients;
- Collect, review, and report CQMs;
- Utilize quality metrics reports to inform quality improvement activities;
- Improve patient safety;
- Assess and document practice progression throughout the transformation process;
- Facilitate efficient, effective improvement team meetings;
- Utilize available external resources, such as consultants, HIT technical assistance, and group learning opportunities to meet specific needs;
- Participate in the planning, hosting, and presenting of project-specific learning collaboratives;
- Effectively collaborate within and across organizations and partner teams, including but not limited to, regional health connectors, community organizations, CHITAs, collaborating organizations, funders, and vendors; and
- Assist and support the program office in summarizing and disseminating experience-related learning by way of team updates, written reports, and/or presentations as may be requested.

Essential Clinical HIT Advisor (CHITA) Functions

In particular, CHITAs will:

- Support the HIT aspects of program-specific practice transformation milestones that typically include data-driven quality improvement, enhanced care team communication, registry utilization, quality measure reporting, risk stratification, population management, among other activities;
- Assess potential gaps in practices' HIT assets. Work with practices to identify, prioritize, and implement strategies to address HIT needs. When HIT needs outstrip the practice and project's means, help practices link to available outside resources, such as those provided by EHR vendor support services and the HIEs;
- Help practices develop sustainable processes for validated reporting of CQMs to external data aggregators. Provide feedback on clinical documentation workflows as well as clinical information workflows to improve the integrity of clinical quality measure reports;
- Work with practices to develop a data quality plan that may include standardized policies and procedures for documentation of key information to ensure quality data for quality improvement use;
- Identify HIT best practices within practices and disseminate lessons learned;
- Actively participate in CHITA trainings and other ongoing planning, development, and learning community meetings; and
- Link practices to new HIT resources available through the local, state, regional and federal HIT programs such as the Regional Extension Centers, Health Information Exchanges, SIM funding, and others.

PTO to Practice Matching Process

The University of Colorado will facilitate the process to match SIM- participating practices with appropriate, approved PTOs. Practice preference will be a primary factor in matching approved PTO vendors with individual practices. In addition to practice preference, other criteria that will enter into the PTO/Practice matching process include: PTO staffing capacity, geographic region of the practice, PTO experience providing specific services that match practice needs, and presence of other restrictions (such as those based around membership, employment relationships, etc.). The final step in this process is the development and mutual adoption of a scope of work and compensation/payment for a PTO/Practice match.

Developing Tools that Support Practices

While transformation assistance will need to be flexible and attuned to the needs of individual practices, common tools and standard approaches will be critically important to assuring the success of practices and transformation organizations. To support both PTOs and practices in achieving practice transformation objectives, the University will develop the following:

- **SIM Implementation Guide**: The SIM Implementation Guide will offer a common set of definitions and approaches to achieving each of the SIM Practice Transformation Milestones, with various options that are appropriate to individual practice characteristics and situations. The Implementation Guide will be supported by the Toolboxes outlined below.
- **Toolboxes of Resources and Training Materials:** The University will curate existing templates, guidelines, and materials in order to support the SIM Implementation Guide. One toolbox will focus on change management and a wide variety of advanced primary care approaches and skills. Another toolbox will focus on behavioral health integration. This toolbox will include extensive resources and materials to support primary care clinicians, behavioral clinicians, and other practice staff in adapting existing models of care integration into their clinical workflows. Toolboxes will build extensively on existing resources from the Agency for Healthcare Research and Quality and other related organizations.
- **Assessment Criteria:** The University will outline criteria and methods to be used in order to assess progress toward achieving practice milestones. These criteria are intended to provide clarity and standardization for practices in the SIM cohorts.
- **E-Learning Courses to support transformation:** InterVision Media will provide professional services to the University for the development of new modules for its Patient Centered Medical Home E-learning program. Eight new modules will include:
    - 1: Introduction to SIM and Practice Transformation Module;
    - 2: Patient and Family Centered Care Module;
    - 3: Integrated and Coordinated Care Module;
    - 4: Team-Based Primary Care Module;
    - 5: Quality Improvement Module;
    - 6: Patient Self-Management Support Module;
    - 7: Population Management Module; and
    - 8: Leadership Skills for SIM and Practice Transformation.

The e-learning modules are closely aligned with the conceptual framework, which was designed with close input from the University team. All practice transformation services and resources have been developed to align with and build on the conceptual framework.

To date, the University has convened a group of 15 paid subject-matter experts to provide guidance and leadership on developing these supports. Three to five subject-matter experts are responsible for ensuring progress on each project.

The University will create draft versions of the Implementation Guide, Assessment Criteria, and Toolboxes, as well as propose topics for E-learning Courses, by January 2016. This information will be presented to the SIM Office and SIM Stakeholder Workgroups will be asked to provide guidance on key elements of these deliverables. For example, in January, the Consumer Engagement workgroup is scheduled to provide feedback on elements of the SIM Implementation Guide related to Patient Experience.

Collaborative Learning Sessions

One of the key objectives of the SIM project is to rapidly identify what works and to disseminate these best practices as broadly as possible. The University will convene twice-yearly collaborative learning sessions for practices, PTOs, and other stakeholders to share general knowledge, identify lessons learned, and disseminate best practices. These collaboratives will continue throughout the SIM project and outcomes will be incorporated into updates to the Toolboxes described above.

Opportunities for Credit

Maintenance of certification credit will be available for participation in the quality improvement work that is at the core of the practice transformation activities. Continuing Medical Education credit will be offered for completion of the e-learning modules and for participation in collaborative learning sessions, structured webinars, and other related activities.

Practice-Specific Approach

The University team and PTOs possess extensive experience working across the entire spectrum of practice types as well as practices with varying degrees of readiness for change. The SIM framework and practice transformation milestones are meant to provide a roadmap for change while simultaneously providing practices with the flexibility to approach the transformation process differently. Additionally, practices will be matched with the PTO that best suits their needs. PTOs will each be responsible for conducting an initial readiness assessment to identify particular strengths and opportunities for each

practice. These assessments will also guide PTOs in matching practices with specific resources within the broader practice transformation toolbox, according to the needs of individual practices. Additionally, PTOs will play a key role in collaborating with practice leadership to create an individualized practice transformation plan that will guide practices on a unique path toward meeting milestones and advancing toward further integration.

Access to Capital

While SIM practices will benefit from the technical assistance outlined earlier in this section, the initial costs of undertaking integration efforts can be prohibitive. In particular, larger-scale investments in infrastructure (such as building out a private exam room for a behavioral health provider), HIT (such as adapting an existing EHR to include behavioral health records), or personnel (such as hiring a behavioral health provider) can present substantial barriers to participation.

In order to mitigate the costs of integration and incentivize practices to make high-impact changes, the Colorado SIM Office plans to take a three-pronged approach to expanding practices' access to capital.

Practice Participation Payments

All practices will be eligible to receive approximately $5,000 to offset indirect costs of participation. Practice Participation Payments will be administered by the University of Colorado. Payments to individual practices from the Practice Participation Fund will be based on ongoing participation in SIM practice transformation and evaluation activities, as well as achievement of specific milestones:

1) Participation in twice-yearly Collaborative Learning Sessions: $500 per collaborative attended by at least two members of a practice's practice improvement team, totaling $2,000 over the course of two years;
2) Quarterly reporting of required measures: $1,000 disbursed after provision of half of the total expected quarterly reports and an additional $1,000 disbursed after receipt of all expected quarterly reports, totaling $2,000 for each practice; and
3) Participation in assessments and evaluation activities: An initial payment of $500 for completing a baseline assessment and a final payment of $500 based on participation in ongoing and final evaluation assessments, totaling $1,000 for each practice.

Payments amount to a total of $5,000 per practice for practices participating in Cohort 1.

SIM Practice Transformation Fund

Colorado SIM has devoted approximately $3.25 million to a Practice Transformation Fund. Grant funds will be available through a competitive RFA to which any SIM practice may apply. Practices will be considered based on need and the level of innovation of the proposed project. The $3.25 million will be distributed to practices over the course of all three award years.

Additionally, The Colorado SIM Office has requested approximately $3 million dollars from The Colorado Health Foundation (TCHF), to be used to support integration efforts in practices that serve a high proportion of Medicaid, Medicare, or underserved clients. Funds would pass from TCHF to CDHCPF, which serves as the fiscal agent for the Colorado SIM Office. If approved, CDHCPF would request a 100 percent match on these dollars and grant them directly to eligible practices, selected in the competitive RFA process.

The SIM Practice Transformation Fund is envisioned as a way to assist practices with some of the upfront costs that will be incurred in the implementation of behavioral health integration. Many participating practices are small, independent, and/or serve underserved populations and have little capital reserves available to absorb such costs. Therefore, the distribution of the SIM Practice Transformation Funds will primarily focus on practice need and the degree to which the proposed use of the funding will assist the practice in accomplishing an advanced level of behavioral health integration. Innovation will also be a factor in the consideration of proposals. Possible examples of innovation could include: 1) initial costs associated with the implementation of shared behavioral health services among several small practices; 2) costs associated with unique partnerships between practices and mental health centers or other behavioral health providers; 3) establishment of evidence-based phone or Internet based behavioral health resources as a method of extending behavioral health services; and 4) other innovative solutions.

Low-Interest Loans

To supplement the grants above, the SIM Office is also exploring additional capital for practices through Vital Healthcare Capital (V-Cap), a non-profit social impact loan fund. If approved by CMMI, V-Cap would offer low-interest loans to a subset of practices (approximately five to seven) that require additional capital to maximize their practice transformation efforts. Loans from V-Cap and grants from Colorado SIM would be made in parallel to participating providers, without interchange of funds

between V-Cap and Colorado SIM. Because funds would flow directly from V-Cap to practices, neither Colorado SIM nor CDHCPF would be at risk should a borrower default on a loan.

Anticipated Benefits

Improve the SIM Value Proposition*:* In addition to providing practices with the resources, coaching, and technical assistance necessary to achieve their goals, SIM must ensure that participating practices have the financial resources to do so as well. However, current SIM grants often fall far short of financing the costs associated with integration, creating a disincentive for practices to participate. Additional funds from TCHF and V-Cap could add value by providing capital-constrained practices with the resources necessary to bridge the gap between vision and reality, incentivizing participation and retention in SIM cohorts.

Maximize Impact: The addition of funds will allow practices to make larger improvements than would otherwise be possible. The larger scope of these projects would maximize the impact of the coaching, resources, and technical assistance already provided by SIM.

Promote Sustainability: Financial constraints may result in practices taking gradual steps toward integration and efforts may stall when SIM funding ends. By providing access to increased capital at the start of the SIM initiative, practices may be able to more swiftly complete initiatives, such as improvements in infrastructure, that produce lasting impact beyond the term of the SIM initiative.

Advance Innovation: While stakeholders have long identified the need for greater coordination between private foundations and state agencies, public-private partnerships to fund transformation efforts are rare in Colorado. With the guidance of CMS, the SIM Office could take a lead role in pioneering the use of public-private partnerships and diverse funding streams to achieve its goal.

Bi-Directional Integration Demonstration Pilot

Background

Colorado SIM recognizes that successful integration cannot only occur within primary care, but must also include venues in which behavioral health care is traditionally offered. As a result, the Colorado SIM has contracted with the Colorado Behavioral Healthcare Council (CBHC) to facilitate and manage a sub-grant program initiative to pilot integrated health homes within four CMHCs.

These integrated Health Homes will provide comprehensive behavioral and physical health care to children, adolescents, and adults to stabilize and manage their illness and support recovery. Because

CMHCs serve as the primary locus of care for many Coloradans, particularly those managing a SMI or addiction, the CMHC-based integrated health home represents the best potential opportunity for the greatest cost reduction for individuals with the highest needs and costs of care.

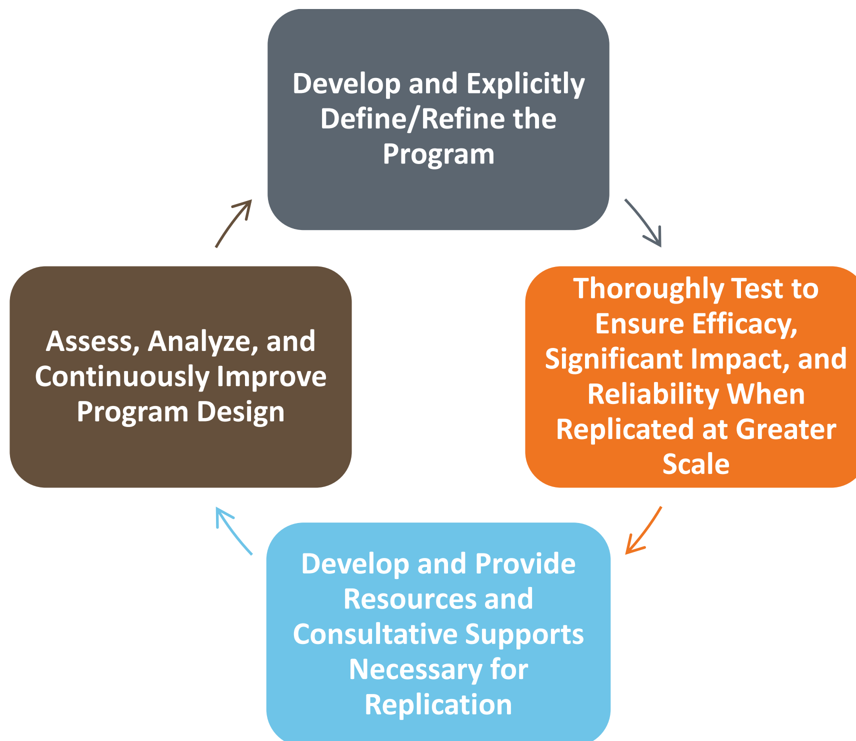
While integration occurs along a continuum, the CMHC-based health homes will strive to achieve the highest level of integration in which behavioral health and medical services are planned and provided through a multi-disciplinary treatment team, leveraging advanced HIT and broader health information exchange efforts. The model will not only incorporate integrated/co-located primary care and ready access to more intensive behavioral health services but will also include comprehensive care planning and management; health care coordination; health promotion/wellness activities; transition support across care settings; individual and family recovery supports; and linkages to community services.

Bi-directional Integration Demonstration & Practice-based Research Pilot Project	
Anticipated Total Funding:	$1,212,000
Number of Awards:	4
Estimated Award Amount:	$303,000 annually
Length of Project Period:	4 Years Year 1: August 2015 – January 31, 2016 Year 2: February 1, 2016 – January 31, 2017 Year 3: February 1, 2017 – January 31, 2018 Year 4: February 1, 2017 – January 31, 2019
Eligible Applicants:	CMHCs Licensed in Colorado

Conceptual Framework

The Bi-Directional Integration Demonstration and Practice-Based Research Pilot Program is founded on four principles of implementation science[28]: develop and define the program well before testing it; test it thoroughly before broad implementation, making sure it is not only efficacious, but can produce results of public health and social importance reliably in settings that will be typical when replicated at greater scale; develop the resources and consultative supports necessary to enable others to replicate the program carefully; and improve it continuously.

[28] Halle T., Metz A., and Martinez-Beck, I. *Applying Implementation Science in Early Childhood Programs and Systems.* Brookes Publishing. 2013; Ch.10: 360.



These principles will guide the work of the selected pilot sites, and drive a high expectation for the function, outcomes, and scalability of CMHC-based Integrated Health Homes. By investing resources and providing clear parameters for testing bi-directional integration in CMHCs, Colorado will gain clarity in determining the highest value approach to preventing the progression of co-morbid physical and behavioral illnesses and treating our state's highest need, highest cost individuals.

Expectations for Participation

- CMHC-based integrated health homes will improve health by providing accountable care across all stages of the risk continuum and increasing access to primary and preventive care, chronic disease management, and wellness services. Integrated services will be available for all clients of the health home, with particular emphasis on those with a SMI. Each bi-directional integrated health home will be required to provide core activities focused in the following target areas:
  - Care Coordination and Health Promotion;
  - Chronic Condition Management and Population Management;
  - Comprehensive Transitional Care; and
  - Individual and Family Support Services.
- Primary care providers will be embedded directly into the CMHC setting and offer services to patients who previously lacked a PCP, had barriers to accessing care, and/or for patients who

perceive the CMHC as their most trusted entrée into the healthcare system. In order to realize this goal:

  - All four CMHC-based health homes will use a standard tool for self-assessment of initial status of integration and will conduct and submit annual updates of that assessment;
  - Physical modifications may be required to transform space previously used for individual, family, and group psychotherapy into medical exam rooms. CMHCs will need to ensure that there is adequate equipment, refrigeration (e.g. for vaccinations), sinks, areas for labs and basic medical procedures;
  - IT infrastructures that are necessary to support integration include population health management tools that are connected to EHRs; technology that supports sophisticated data collection and reporting; and technology and systems required to facilitate health information exchange (such as through exchange of Continuity of Care documents). CMHCs require capabilities to identify patients who lack a PCP and connect them to the integrated health home; and
  - Awardees will support direct services necessary to support whole person care that includes 1) Risk-stratified Care Management; 2) Access and Continuity; 3) Planned Care for Chronic Conditions and Preventive Care; 4) Patient and Caregiver Engagement; 5) Coordination of Care across the Health Neighborhood.

- CMHC-based Integrated Health Homes will be required to identify areas where private and public insurance is inadequate or not in line with the principles of parity and contribute to reports to the CDHCPF and the Colorado DOI in order to guide changes to promote parity and sufficient benefit coverage. Integrated Health Homes will also be required to articulate and implement a glide path to payment reform that:
  - Begins with payments to support implementation expenses, personnel, clinical and fiscal data collection, integration activities, and services not currently covered by payers;
  - Braids the above funds with existing payment streams including Medicaid, Medicare, and third parties, on both the physical and behavioral health side; and
  - Moves toward a shared bundled case rate for patients who need the CMHC health home long-term with both the behavioral and physical health care dollars combined into a single bundled and risk-adjusted payment.

Current Status

The Request for Proposals (RFPs) were released to all Colorado CMHCs in August 2015. CMHCs were encouraged to develop comprehensive proposals that demonstrated capacity to meet SIM goals and create lasting, transformational change. Proposals were due in September 2015 and in total, 11 CMHCs submitted proposals.

CBHC and the Colorado SIM office partnered with the Keystone Policy Center to ensure a fair and transparent review process. Keystone convened an independent selection panel of reviewers who were chosen based on their knowledge of integration, behavioral health, and SIM as well as their ability to evaluate the feasibility and merit of proposals as they related to the proposed learning process of bi-directional integration.

It was a highly competitive application process that clearly demonstrated the strength, innovation, and dedication of Colorado's behavioral health network. Ultimately, the following four sites were selected to participate in the bi-directional integration pilot program:

- Community Reach Center;
- Jefferson Center for Mental Health;
- Mental Health Partners; and
- Southeast Health Group.

Next Steps

Year 1: Through January 2016 - Ramp Up and Implementation

- Once specific sites are identified, a ramp-up period funded by SIM grant funds will allow CMHCs to make physical modifications to the clinic sites, fill any new staff positions, develop contracts/Memorandums of Understanding (MOUs) with PCPs (if applicable), augment their HIE and HIT infrastructures, establish clinic and case management procedures and communication protocols, and participate in training on SIM performance metrics.
- CBHC Project Director will conduct a single site visit to each new health home, conduct weekly calls with each clinic manager to monitor ramp-up, and refine expectations for health home data collection and reporting related to the Bi-directional Integration & Practice-based Research Pilot Program and the wider SIM initiative.
- Each site's plan to develop the data needed to propose a sustainable payment model will be reviewed and support will be provided to address challenges.

- The CBHC Project Director will also conduct at least one videoconference with representatives from each of the four funded health homes to share information about each site's plan and approach and establish communication among the four sites' leadership staff to support peer problem-solving and learning.
- Health homes will conduct patient enrollment, initial primary care visits, develop and refine necessary work flows, and implement or refine provider team communication mechanisms. Data will be gathered as patients start to receive care.
- Patient-specific and population-based data collection underway; process measures and practice transformation metrics tracked and reported at regular intervals.

Years Two through Four – Demonstration & Evaluation

- Sites will be fully operational and the model will be in full implementation. Regular communication will be established among four sites to support ongoing peer problem-solving and learning.
- Ongoing patient-specific and population-based data collection underway; process measures and practice transformation metrics tracked and reported at regular intervals.
- CBHC and CMHCs collaborate to compile, synthesize, and apply data from each site on clinical, operational, and fiscal metrics to inform, continuously refine, and improve care delivery model.
- Data analytics used to substantiate evidence base for bi-directional integration and inform local providers, the SIM leadership team, payers, and policy makers about the effectiveness of these types of health homes and what is necessary to sustain them in the future.
- Pilot Sites develop final reports on all defined performance metrics, outcomes, cost savings, and lessons learned. Submit documented, sustainable, and replicable models including clinical, operational, and financial model details.
- CBHC submits final report detailing aggregate data on health outcomes, financial savings, and all other performance metrics.

At this time, the CMHCs are not eligible to apply for SIM Practice Transformation Fund (PTF) funds. CBHC anticipates using funds allocated to the bi-directional integration sites to engage with practice facilitators, practice transformation organizations, clinical health information technology advisors (CHITAs), and regional health connectors (RHCs). Additionally, CBHC staff and individuals from the bi-directional sites maintain close involvement with the broader SIM initiative to ensure strong alignment.

The CBHC SIM Project Lead serves as the co-chair of the SIM Policy workgroup and a key representative from one of the bi-directional sites serves as the co-chair of the SIM Practice Transformation workgroup. Both of these individuals also serve on the SIM Steering Committee. In addition, CBHC staff maintain a strong presence and engagement with the other six SIM workgroups and the Advisory Board.

The CMHC bi-directional integration health home sites will serve as a pilot for replication and expansion of bi-directional integrated care in the future. The four sites have already formed a learning collaborative that will regularly convene to share ideas and efforts with one another, and establish key avenues for peer-supported problem-solving and innovation. Through this pilot program, each site will develop and share key information regarding their clinical, operational, data, and fiscal models. The CMHC sites will actively create alignment with the SIM primary care practices through data collection, reporting and progress toward the practice transformation milestones. This network of key activities will generate crucial learnings to understand what it takes to make integrated care work in the community mental health center setting, setting the stage for future integration efforts.

Regional Health Connectors (RHCs)

RHCs will play a critical role in supporting practice transformation efforts, as they work to break down silos between providers, the public health system, and social services and other local resources. The University plays a leadership role in CHES and will integrate RHCs as a key part of their transformation efforts. Please see the ***Plan for Improving Population Health section's RHC subsection*** of the Operational Plan for more information about the roles of RHCs.

Practice Transformation and Service Delivery Workgroup

Current Status

The Practice Transformation Workgroup consists of 17 members who provide guidance on all aspects of SIM practice transformation efforts and work to ensure that key dependencies are communicated to other workgroups. Since July 1, 2015, the workgroup has met ten times and has provided feedback and guidance on the following topics, among others:

- Defining Primary Care;
- Eligibility and Selection Process for Cohort 1 SIM Practices;
- Selection of Practice Transformation Milestones;
- Selection of CQMs;

- The Value Proposition for Joining SIM Cohorts;
- HIT Needs to Support Practice Transformation;
- Identifying Key Messages to Potential Practices;
- Elements and Goals of the Practice Assessment Tool; and
- Coordination between Bi-Directional Health Homes and Primary Care Practices in the First SIM Cohort.

Next Steps

The workgroup will continue to meet at least once per month. Future topics of conversation include:

- Intersections with the Policy Workgroup and identification of policy issues that may hinder or support practice transformation efforts;
- Intersections with the Consumer Engagement workgroup, particularly ways in which the workgroup can support practices in achieving the activities outlined in the Patient Experience Milestone; and
- Feedback on aligning opportunities for disseminating provider education (including SIM-funded and other related opportunities).

Component Summary Table

SIM Component/Project Area: *Health Care Service Delivery Transformation Plan*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Finalization of First Cohort	Agreements signed with approximately 100 primary care practices to participate in the First SIM Cohort	SIM Office	Practice Transformation	Agreements with at least 90 practices in place to participate in first cohort
Practice Transformation Organization (PTO) Training	PTOs undergo training on methods for supporting SIM-participating primary care practices	University of Colorado	Practice Transformation	Training for PTOs held in Q1 of 2016; all funded PTOs attend
Online Practice Transformation Modules	Eight online modules developed and posted online for use by SIM-participating practices	Intervision (subcontractor of the University)	Practice Transformation	Eight training modules are available for practices in all cohorts of SIM
SIM Implementation Guide and Toolbox of resources	Practices have access to a guide and toolbox that offer information on participating with SIM, useful resources, and templates	University of Colorado	Practice Transformation	Completion of SIM Implementation Guide and Toolbox in time for start of first cohort
Biannual Learning Collaboratives	Learning collaboratives are hosted for SIM-participating practices twice a year, allowing them to share best practices and lessons learned	University of Colorado	Practice Transformation	At least two learning collaboratives held each year, with representation from at least 90% of SIM-participating practices
Clinical Quality Measures (CQM) reporting	SIM practices report on requires clinical quality measures quarterly	University of Colorado, with support from Practice Transformation Organizations	Practice Transformation, Health Information Technology	All SIM participating practices and Bi-Directional Health Homes submit quarterly CQM data
Practice Transformation Fund	Practice Transformation Fund established. Practices can apply to fund to cover up-front costs of integration	SIM Office to establish fund, Department of Health Care Policy and Financing to conduct RFA	Practice Transformation	Fund of at least $3.25 million established
RFA for Second Cohort SIM Practices	RFA released to solicit applications from primary care practices that wish to participate in the Second Cohort	University of Colorado	Practice Transformation	RFA released, goal of selecting 150 practices for participation

SIM Component/Project Area: *Health Care Service Delivery Transformation Plan*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Patient enrollment in Bi-Directional Health Homes Integration Pilot	Bi-directional health homes enroll patients in pilot, with a focus on patients who are not accessing primary care elsewhere	Funded Health Homes	Practice Transformation	Number of patients enrolled
Health Homes Peer-Supported Learning Groups	Videoconference and peer-supported learning group convened to address ramp-up success/challenges and payment models	Colorado Behavioral Health Care Council	Practice Transformation	Convenings held at least once per quarter
Site visits to health homes	Initial site visit conducted to all health homes	Colorado Behavioral Health Care Council	Practice Transformation	Each health home receives a site visit

Payment and Service Delivery Models

Payment reform is a key component in Colorado SIM's efforts to provide 80 percent of Coloradans with access to integrated primary and behavioral health care in coordinated community systems, with value-based payment structures, by 2019. Current payment systems, which reimburse care primarily through FFS payments and utilize a range of payer-specific measures to evaluate outcomes, compound the fragmented and "siloed" nature of care delivery within the state and create a significant barrier to integrated care. To achieve lasting and sustainable change, payment reform must go hand in hand with efforts to transform health care delivery.

Overview of Payment Reform in Colorado

The insurance markets in Colorado are highly fragmented, consisting of more than 400 health insurers including self-insured businesses. The ten largest health insurance companies operating in the state, based on the highest amounts of earned premiums, constituted 74 percent of the state's market share in 2013.[29] While competition is considered one of the strengths of the Colorado marketplace, and ensures consumers have a broad selection of insurance options available, it also poses a barrier to creating structural change, as the actions of any one payer are unlikely to shift the market. A signification amount of variation also exists among payers, which range from small, local non-profits to large, publicly-traded health insurance organizations and sophisticated integration systems. This fragmentation within the marketplace makes the spread of value-based payments across payers, which have varying resources, capacities, and strategies at their disposal, an ambitious enterprise.

Despite these challenges, multiple public and private value-based payment initiatives are currently underway in the state. Over the summer, a Michael S. Dukakis Fellow with the Governor's Office conducted interviews with stakeholders across the state, to examine the barriers and opportunities to move Colorado's market towards value-based payments. Although payers indicated a high degree of interest in pursuing such models, many expressed a need for state guidance and leadership around key issues, including a common or standardized set of performance metrics; minimum reporting standards, based on "best practices"; and establishing processes and support for data sharing. The SIM initiative will play a leading role in addressing these issues, and other perceived and real barriers to the adoption of value-based payments.

[29] Colorado Department of Regulatory Agencies, Division of Insurance. Health Insurance Cost Report to the Colorado General Assembly for Calendar Year 2013.

Colorado SIM Approach to Payment Reform

Engagement with Public and Private Payers

Colorado SIM has worked with payers and providers over the last several months to develop a payment reform strategy that meets payers and practices where they are and works to move them away from FFS reimbursement structures toward alternative payment models that incent quality and value rather than volume. SIM will build off current commitments and efforts toward payment reform – effectuated through participation in initiatives including CPCI, the Colorado Medicaid ACC program, and independent projects undertaken by various commercial insurers – to capitalize on payers' previous investments of time, infrastructure development, and philosophical alignment. Utilizing this platform of existing work will ensure maximum payer participation in SIM, and catalyze SIM's efforts to reach 80 percent of state residents by 2019.

Multi-payer Collaborative (MPC)

As previously noted, Colorado was one of seven regions selected by CMS to participate in CPCI. Unique to Colorado, however, the private and public payers participating in this initiative voluntarily came together in 2012 to form a self-funded, self-governing body committed to supporting payment reform and practice transformation efforts in Colorado, known as the MPC. The MPC currently includes nine commercial payer organizations (Aetna, Anthem Blue Cross Blue Shield, Cigna, Colorado Access, Colorado Choice, Humana, Kaiser Permanente, Rocky Mountain Health Plans, UnitedHealthcare) as well as the CDHCPF, and meets on a monthly basis, every other month in person for a minimum of a half day.

Relationship between the Multi-Payer Collaborative and SIM

Several of the local and national private payers participating in the MPC issued a joint press release in June 2015, publicly pledging their continued support of payment reform efforts in Colorado – including supporting SIM's efforts to integrate physical and behavioral healthcare. The press release was accompanied by a payer reception at the Governor's Mansion, hosted by the SIM Office, where Governor John Hickenlooper commended the payers' initial commitments.

In August, MPC produced the following message to stakeholders interested its efforts to align with SIM and support alternative payment reform and practice transformation in Colorado.

> *"Colorado payers, both public and private, are working together to develop a framework for achieving whole person care through comprehensive practice transformation. Using this framework, payers will be expanding value-based payments within their own networks to practices engaged in transformation activities, and meeting specific milestones. Practices will be able to participate to*

advance their knowledge and demonstrated ability to support this model of care, at the level that makes the most sense to them. A wide range of participants, from practices in the early stages of transformation to groups with extensive transformation experience, will be included in the initial cohort. An additional financial stipend will be paid by the Colorado SIM Office to participating practices in consideration of their decision to undertake this course of work.

The SIM Office will select practices participating in Colorado SIM. Payers will direct their own investments toward the sources of care that are most likely to produce a return — which are associated with intermediate and advanced practice competencies in the framework. Colorado payers are also working to align their payment, measurement and data sharing processes in a way that will help practices, similar to what the Multi-Payer Collaborative accomplished with the CPC Initiative. It is anticipated that practices who participate in Colorado SIM, and persist in advancing through components of the model, will greatly improve the likelihood of receiving enhanced funding from both private and public payers. Practices will also likely create additional capacity to serve larger groups of patients more efficiently — which can improve sustainability and financial performance even in the absence of reformed payment.

The process of change is challenging, uncertain, and risky, but correlated with many potential rewards for both providers and patients. Colorado payers are working collaboratively to support this process of change with equivalent uncertainty and risk. The most important part of the process is to take the first step forward, and then to continue forward movement. The process of change also requires the MPC to be nimble and to adjust according to changes in the Colorado market and health care landscape. As a result, the work of the MPC, and this document, will continue to evolve."

The MPC will serve as the primary forum for SIM's engagement with public and private payers throughout the implementation of the model test. However, the SIM Office will continue to engage with payers and other stakeholders outside of this setting, to inform and direct payment reform activities, as outlined below.

SIM Payer Workgroup

In addition to the MPC, which convenes on a monthly basis, the SIM office believes it is important to engage stakeholders beyond those representing the insurers to provide recommendations on designing alternative payment models that supports integration of behavioral health and clinical care. The SIM Payers, Purchasers, and Payment Reform Workgroup was formed to compliment the efforts of the MPC, and includes a wider range of stakeholders, including consumer representatives, philanthropic organizations, and state agencies.

The MPC will work closely with the other SIM Workgroups; this bi-directional flow of information and discussion will be facilitated through individuals who sit on multiple groups, and have knowledge and expertise on various SIM components.

Medicare Participation in SIM

While the 10 public and private payers currently participating in the MPC provide a strong foundation for SIM's payment reform efforts, these organizations and the Colorado SIM office believe that Medicare's active participation is critical to the overall success of the SIM initiative. Given market dynamics described below, payers need Medicare participation to achieve saturation of value-based payments. Likewise, CMS will be unable to achieve payment model reform without active participation of the payers in the MPC. As a result, in August, the MPC submitted a request to CMS, asking for the active and ongoing participation of Medicare in the MPC, and in SIM's proposed care delivery and payment reform approach for the following reasons.

State Demographics

Colorado is currently in the midst of a significant demographic shift – dubbed the "silver tsunami" – in which the population aged 65 years and older is experiencing an unprecedented period of growth. Between 2000 and 2010, for the first time in the state's history, the 65 and older population grew at a faster rate – showing a 32 percent increase (133,552 people) – than total state population, which grew at 17 percent.[30] The number of Coloradans aged 65 and older is projected to increase by 61 percent between 2010 and 2020, from 549,629 to 891,970, making this the fastest-growing decade for this population.

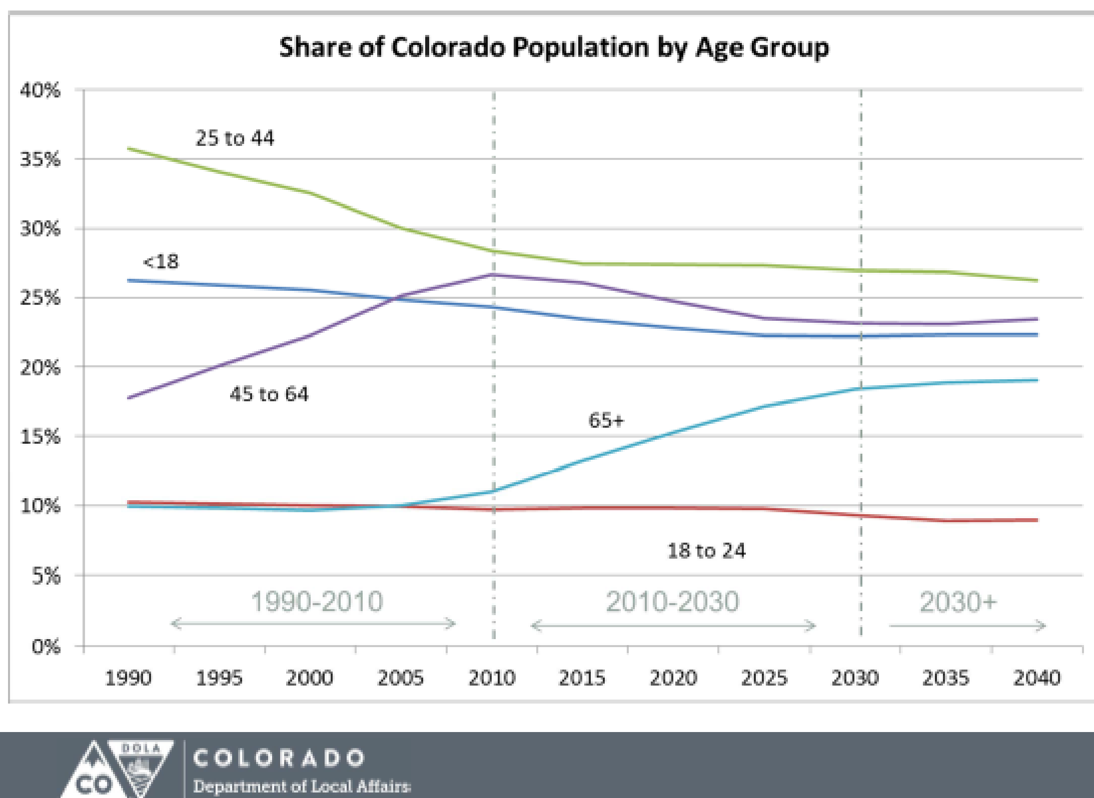
Historically, Colorado has attracted a large number of individuals aged 23-35, leading to an age distribution with a larger share of the population younger than 65 and relatively few people over the age 65. In 2010, Colorado had the fourth-lowest share of individuals older than 65 in the U.S. Those seniors constituted just 10 percent of the state's population (compared to 14 percent nationwide).[31] However, that same year, the leading edge of the "Baby Boomer" generation (born between 1946 and 1964) began aging into the 65-74 age cohort, at a rate of around 7 percent per year. By 2014, Colorado's

[30] Colorado Department of Local Affairs, State Demography Office. *Aging in Colorado*. July 2012. Available at www.colorado.gov/demography.

[31] Colorado Department of Local Affairs, State Demography Office. *Colorado Population Forecast: A Tale of Three Regions, Impacts of an Aging Colorado*. Fall 2014. Available at www.colorado.gov/demography.

population aged 65+ increased more than 23 percent (almost 130,000 people), and Colorado had fallen to seventh among states with the lowest share of individuals over 65.[32]

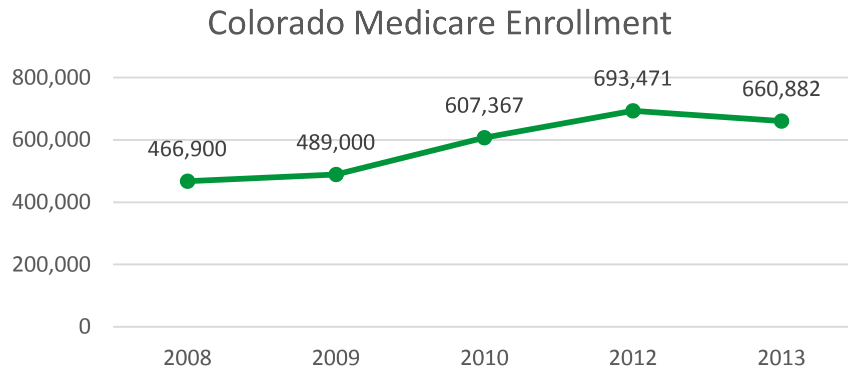
The State Demographer's Office forecasts the number of Coloradans aged 65 and over will increase by 61 percent between 2010 and 2020, growing from 549,629 to 891,970.[33] During this time, 155 Coloradans will be turning 65 each day.[34] By 2040, Colorado's 65+ population will represent 19 percent of the state's total population (close to 1.5 million people), representing an increase of more than 160 percent compared to 2010 and an increase of 116 percent compared to 2014.[35] The median age of the state is projected to rise from 36.4 to 39.4 by 2040.[36]



[32] The Bell Policy Center. *Presentation on Aging Issues: House Committee on Public Health and Human Services Committee.* January 20, 2015. Available at http://www.leg.state.co.us/Clics/Clics2015A/commsumm.nsf/b4a3962433b52fa787256e5f00670a71/df9751ac250088e387257dd300702878/$FILE/150120%20AttachC.pdf.
[33] Colorado Department of Local Affairs, State Demography Office. *Aging in Colorado*. July 2012. Available at www.colorado.gov/demography.
[34] Colorado Department of Local Affairs, State Demography Office. *Colorado Population Forecast: A Tale of Three Regions, Impacts of an Aging Colorado*. Fall 2014. Available at www.colorado.gov/demography. Tale of Three Cities
[35] Presentation
[36] Colorado Department of Local Affairs, State Demography Office. *Colorado Population Forecast: A Tale of Three Regions, Impacts of an Aging Colorado*. Fall 2014. Available at www.colorado.gov/demography.

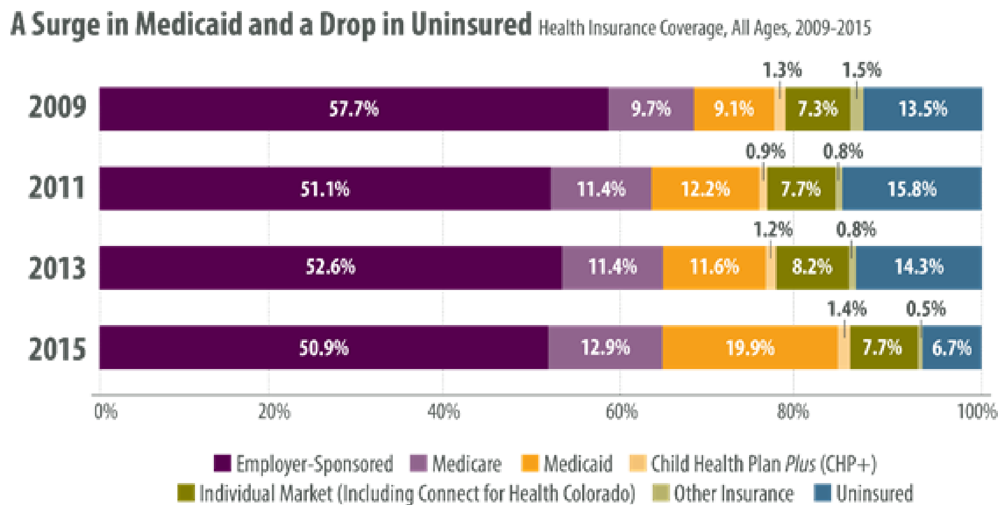
Medicare Enrollment

Annual data collected by the Colorado DOI reflects a steady increase in the number of Coloradans covered by Medicare between 2008 and 2012, with a slight dip occurring in 2013 (no data available for 2011).



Source: Colorado DORA, DOI – Health Cost Report

More recent data from the 2015 Colorado Health Access Survey (CHAS) indicate that the number of Coloradans with access to health insurance increased to nearly 5 million (4,941,565) in 2015, reducing the percentage of uninsured state residents to 6.7 percent (from 14.3 percent in 2013). In addition to this increase, the type of insurance coverage is also changing: In 2015, approximately one-third of Coloradans (34.2 percent) are covered by public insurance, compared to 24.2 percent in 2013. Per CHAS, the percentage of Coloradans enrolled in Medicare increased from 9.7 percent in 2009 to 12.9 percent in 2015.



Engaging the Self-Insured, Including State Employees

The Colorado SIM Office has had encouraging conversations with the Department of Personnel Administration (DPA), which oversees the state employees' health benefit plan. DPA has agreed to support the SIM initiative, and will work with the SIM Office to explore the use contractual requirements around the availability of integrated care and the use of alternative payment models in the upcoming re-procurement process for the State Employee Health Plan. This will extend SIM's reach to the roughly 30,000 state employees and dependents currently receiving coverage through a self-funded plan administered by UnitedHealthcare, and a fully-insured Kaiser Permanente product. The SIM Office will work closely with staff at DPA to explore specific contract amendments and value-based insurance design opportunities for the next contract year, due to begin on July 1, 2016. As part of this process, SIM will explore the feasibility of developing "standardized" contractual language and requirements that may be utilized as a model for other payers. In addition, SIM will engage DPA in a dialogue regarding participation in the SIM minimum dataset, the inclusion of state employee data in data aggregation, and the use of consumer engagement tools.

Colorado SIM has also been in early dialogue with the Colorado Business Group on Health (CBGH), which represents 17 self-funded groups from across the state. The CBGH was formed in 1996, and helps Colorado employers get more value for their healthcare dollars by providing tools, programs, reports, and other assistance to facilitate the development of market-based approaches to lowering healthcare costs while improving quality. Recently, the CBGH facilitated the participation of several self-funded employers in the Healthcare Incentives Payment Pilot (HIPP), a three-year statewide initiative based on the PROMETHEUS Payment® program,[37] funded by TCHF. The SIM Office anticipates an ongoing, productive relationship with the CBGH to exchange knowledge and identify best practices from various state initiatives. This affiliation will provide an avenue for engaging with the self-funded business community to drive demand for integrated behavioral health, ensuring Colorado's premier innovations are complementary to one another, rather than competing.

Veterans Administration and TRICARE

Colorado SIM has engaged in preliminary discussions with the VA and Tricare, and will continue to explore how to work with these agencies in the future around SIM initiatives. According to the U.S.

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[37] The PROMETHEUS Payment® was created by the Health Care Improvement Initiatives, Inc. (HCI3), and uses data from insurance claims to measure costs associated with potentially avoidable complications (PACs) in patients with chronic diseases. This data is then shared in shared with providers in clinically-based actionable reports through PROMETHEUS program, which allows them to detect and reduce spending on PACs and achieve cost savings.

Census Bureau, in 2014 approximately 4.5 percent of Americans, or 14,143,000 individuals, received health care through the military – including TRICARE, CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), and care provided by the Department of Veterans Affairs and the military.[38]

Payment Reform and Practice Transformation

Colorado SIM's payment reform approach allows payers and providers to work collaboratively to establish payment structures that most effectively support the transition to integrated care delivery models; however, the SIM Office recognizes that this pathway may not always represent a smooth and linear progression. As noted in the ***Health Care Delivery Transformation Plan*** section of Operational Plan, practices participating in SIM will progress towards the integration of physical and behavioral health care following the Building Blocks framework adapted from Bodenheimer. The MPC has agreed to this conceptual framework, including the components of the Building Blocks for both practices and payers, and is currently working on the details, including shared definitions and metrics, behind each of the model components ("Blocks"). This framework has been shared with and adopted by the practice transformation work being done under SIM.

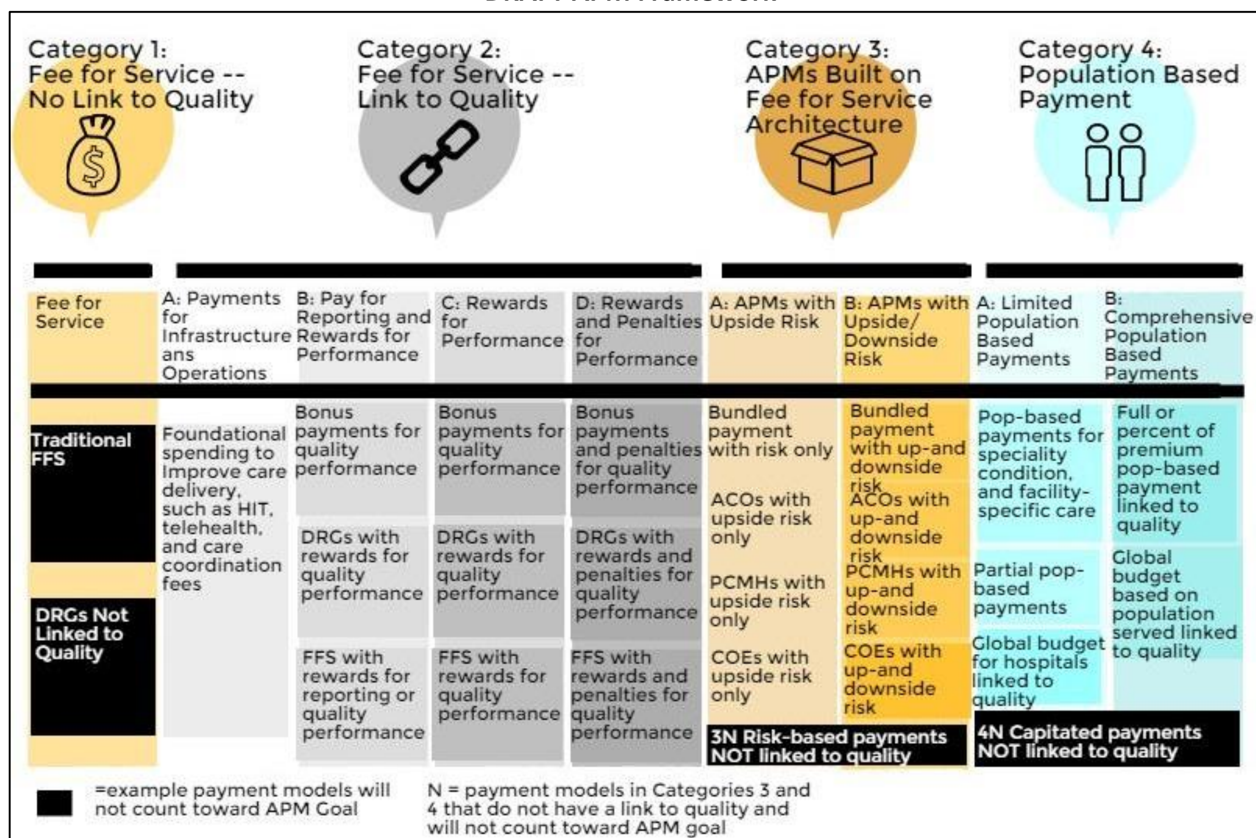
The overarching goal of the MPC is to support value-based payment reform efforts in the state that enhance the integration of behavioral health and primary care. The MPC is dedicated to transforming not only care delivery, but also the manner in which care is paid, and the way in which success is measured. Members of the MPC believe that enhanced payments for primary care services by individual payers has been shown to help improve the availability of care and initiate individual transformation processes. These enhanced payments may take different forms for payers based on their particular programs, market realities, and payment methodologies, but the majority of payers have committed to continuing their CPCI model with additions focused around behavioral health. The MPC is committed to a systems transformation approach whereby the provision of high-value, integrated, whole person care is supported by an integrated investment by multiple payers in infrastructure, quality, and efficiency. Tying payment from multiple plans to advanced primary care will accelerate adoption of cutting-edge integrated care delivery of Colorado's SIM model.

[38] Smith, Jessica C. and Carla Medalia, U.S. Census Bureau, Current Population Reports, P60-253. Health Insurance Coverage in the United States: 2014: U.S. Government Printing Office, Washington DC 2015.

Payment Models

Colorado's SIM application initially outlined a "glide path" approach to payment reform, which envisioned payers and practices progressing through four phases of a payment trajectory pathway. Each phase contained a prescribed list of the various activities that payers and providers would undertake, in order to advance care delivery and payment systems away from siloed delivery systems and fee-for-service payment arrangements, to fully integrate care models, supported by global payments. Based on extensive conversations with stakeholders, the SIM Office has pivoted from this linear and highly categorized approach, and adopted a methodology that aligns with Alternative Payment Models Framework (APM Framework) proposed by the Health Care Payment Learning and Action Network (HCPLAN). The APM Framework outlines four basic categories of payment models, similar to the "four phases" initially proposed by Colorado SIM, but incorporates a much more nuanced understanding of the various payment arrangements that may be included in each category.

DRAFT APM Framework



Source: Health Care Payment and Learning Action Network, Alternative Payment Model (APM) Framework Draft White Paper, Version Date: 10/22/15

One of the guiding principles of the APM Framework, shared by Colorado SIM, is the belief that "as delivery systems evolve, the goal is to drive a shift towards shared-risk and population-based payment models, in order to incentivize delivery system reforms that improve the quality and efficiency of patient-centered care."[39] Colorado SIM is committed working with payers and providers to focus attention on this *shift*, rather than achieving a universal end stage of fully integrated practices and global, capitated payments, which may not be practical or desirable in certain areas of the state.

Colorado's approach to payment reform remains grounded in the realization that that not all providers are at the same level of readiness to accept prospective, value-based payments, and will need support to move towards integrated care delivery systems without jeopardizing patients' access to care or providers' solvency. Provider entities must have sufficient time and technical assistance to put in place the administrative and clinical systems and assemble the financial reserves necessary to successfully accept risk. In addition, payers need time to adapt their payment systems from retrospective claims processing platforms to prospective payment models.

As part of the implementation planning process, payers are currently working to identify the payment models that they will be employing as part of the SIM initiative. Discussions with payers to date indicate the payment support approaches will include a "core set" of models similar to what payers are utilizing for CPCI participating practices, but that some payers will be developing new models. The SIM Office will use the LAN framework to categorize these models for tracking and reporting purposes, but will allow payers flexibility in developing the specific reimbursement mechanisms to allow for internal business needs and demands.

Practice Selection for Initial SIM Cohort

In addition, the nuances of the payment models will necessarily depend upon the features and capacities of the practices that they will be used to support. In response to the Practice RFA for the first SIM cohort, which will start on February 1, 2016 and include 100 practice sites, the University of Colorado (University) received 179 applications that met the qualifying criteria from practices across the state.

[39]Alternative Payment Model Framework and Progress Tracking (AMPT FPT) Workgroup. (10/22/2015). *HCPLAN Alternative Payment Model (APM) White Paper*.

Application Review Process

The University completed a comprehensive review and evaluation process of each practice application. All applications were reviewed by a multi-stakeholder panel, or Application Evaluation Committee (the Committee), convened for the purpose of making recommendations to the SIM Office regarding practices for Cohort 1 of the SIM Practice Transformation Program. The Committee was comprised of subject matter experts that met identified characteristics to ensure the integrity of the application evaluation process.

Practices that met the basic eligibility criteria outlined in the RFA were ranked, based on required and preferred characteristics, as well as their application responses. Additional characteristics of qualified practices were then reviewed in order to ensure a balanced mix of practices to provide a diverse cohort that reflects a variance in geographic distribution, practice size, practice ownership structure, urban/rural locations, and varying points on the behavioral health integration continuum. Total points were tabulated, applicants were scored, and a ranked list was provided to the SIM Office, which made the final determination of practice selection in Cohort 1. A complete description of the practice eligibility criteria, and the application review and selection process, can be found in the Colorado SIM Practice RFA, attached as ***Appendix D***.

Payer Designation of Practices

In September of 2015, payers in the MPC created a list of practices that they would be willing to support with alternative payment models. Payers used their own set of requirements to select their set of practices based on their existing plans to either enhance or expand value based payments.

Concurrent with the University review process, facilitators from the Oregon Health and Science University (OHSU) compiled a single, de-duplicated list of the practices that were identified by one or more payers. This list was then cross-walked against practices that are currently participating in CPCI, and those that applied to participate in the first SIM cohort.

Final Determination of First Cohort Practices

As part of the final selection process, the SIM Office compared the University’s list of ranked recommendations against the list of practices payers have designated as potential recipients of APMs. The SIM Office sought to include practices that are highly ranked by the University and designated by one or more payers in the first cohort, but this was not the sole basis for selection. The SIM Office made final determinations based on the University’s recommendations, the payer’s recommendations, and the diversity criteria outlined in the RFP.

Memorandum of Understanding (MOU)

In support of SIM, members of the MPC are working together to create a MOU that outlines payer commitments in the following areas:

1) Enhanced financial support for primary care practices in their networks or delivery systems that are participating in SIM;
2) Sharing data with participating primary care practices;
3) Aligning quality measures with SIM minimum data set; and
4) Using a common approach to accountability, following the practice milestones established by the SIM Office.

The MOU is anticipated to be executed no later than January 20, 2016. To date, payers have agreed to use good-faith efforts to contract with the practices selected to participate in SIM. Payers will sign agreements to provide value-based payments to primary care practices in their networks identified for the SIM initiative ("payer participating primary care practices"), based on each practice's progress toward achieving comprehensive and advanced primary care transformation capacities. The payer/practice agreements may require that practices meet specific payer thresholds or other conditions prior to qualifying for payments. The structure, qualifications, and amount of these payments will be the responsibility of each payer to determine or negotiate with payer participating primary care practices in their network.

For payment purposes, payers will continue to utilize their respective, proprietary attribution methodologies operationalized for CPCI for SIM. For other purposes, such as reporting to CMS, reporting back to participating practices, and evaluation, Colorado SIM is working with payers, Milliman, CIVHC and other key stakeholders to develop a strategy attribution. Colorado SIM has engaged vendors in research to identify evidence-based attribution methodologies and anticipates utilizing one consistent methodology for all purposes outside of payment to practices. Colorado SIM is working to align the selected attribution methodology with TCPI.

Upon finalization of remaining details, and the execution of the MOU, payers will develop and submit a final description of their proposed payment models an addendum to the MOU, anticipated to be delivered to the SIM Office by the end of January 2016. A draft copy of the MOU is attached as ***Appendix E.***

Quality and Outcome Measures

The alternate payment models employed under Colorado SIM will incorporate the use of quality and outcome measures, tying payments to metrics defined by the SIM minimum dataset. To ensure quality, safety, efficiency, and patient-centered care, a proportion of payments will be performance-based and paid dependent upon achieving specified outcomes. Quality incentive payments will depend on consensus goals and the use of validated process and outcome measures agreed upon by payers and providers.

Clinical Quality Measures

CPCI provided a solid foundation on which to build clinical measures for SIM, allowing SIM to leverage and expand upon existing payer and provider efforts and commitments to quality measurement and reporting. SIM's CQMs start with the basic CPCI measure set, however, since SIM's focus is on the integration of behavioral health and primary care, three measures were added: SUD screening, along with anxiety and depression screens.

For a complete description of the CQMs included in the SIM minimum dataset see the ***Program Monitoring and Reporting*** section of the Operational Plan.

Cost and utilization measures

Cost and utilization measures will be collected by the SIM Office for multiple purposes. Practices participating in SIM will receive aggregate total cost of care and utilization data on a quarterly basis to help inform and direct their practice transformation efforts. In addition, the SIM external evaluator and CMMI will receive cost and utilization data as part of the ongoing impact/outcome analysis of SIM initiatives.

SIM's evaluation of costs of care and utilization will include a measurement of the costs of implementation of integration efforts at start-up and throughout the project, and will examine the business case and sustainability of the model from multiple perspectives, including providers, private payers, purchasers, and federal and state government. Data from Colorado's APCD and other claims databases will be analyzed to conduct an aggregate Return on Investment (ROI) analysis. Together, measurements of quality, health outcomes, patient/provider satisfaction, implementation costs, and health care utilization and costs will document and describe the integration of behavioral health and primary care, the proportion of patient panels under alternative payment methods at baseline and

throughout the project, and whether integration of behavioral health in primary care affects contracting and purchasing decisions and use of value-based payment models.

For a complete description of the cost and utilization measures included in the SIM minimum dataset see the ***Program Monitoring and Reporting*** section of the Operational Plan.

Stratus

Under CPCI, the majority of payers participating in the MPC contacted with Rise Health to develop an innovative data-aggregation online tool, Stratus™, which was shared with participating practices and allows providers to access their patients' claims data from one website. Prior to this tool, providers received multiple reports from each health plan, and had to log on to several different websites to access patient data, making it cumbersome and inefficient for care providers to coordinate a patient's care.

Rise Health partnered with Colorado's CIVHC and other state and local entities to build the tool and help ensure a comprehensive approach to data aggregation. Primary care practices participating in CPCI are utilizing the Rise Health Ascend intelligence engine and Stratus predictive analytics application to access multiple payer reporting; from there, providers use the information to achieve CPCI's milestones. Types of data being used include summary reports and a series of quality metrics previously agreed upon by CMS and payers.

The MPC has agreed to extend use of the Stratus™ tool to practices participating in the SIM initiative. Payers will work with the SIM Office to produce a written plan by February 1, 2016 that outlines how they will transition and expand Stratus™ to additional practices participating in SIM to give providers in SIM practices the capacity to more effectively analyze and apply data to transform their delivery of care.

In addition, payers will use the Stratus tool to provide aggregated data on total cost of care, utilization, and CQMs to the SIM Office and CMMI evaluator on a quarterly and/or annual basis, as required.

Scope of Impact

We anticipate that 37 percent of Colorado's non-Medicare revenue will be part of our payment model. More significantly, we anticipate that this shift will impact a substantial portion of the market that is currently excluded from the calculation as Colorado alters the market standard for payers and providers. We expect the largest healthcare savings will be obtained from the program's impact on members with co-morbid chronic medical and behavioral conditions while the smallest impact will be with members with neither condition. The membership populations underlying our Per Member Per Month (PMPM)

claim cost development represent a subset of the Colorado state totals for each eligibility types, representing 100 percent of the estimated Colorado insured population in 2012. The program will increase the utilization of primary and behavioral healthcare services and improve clinical and financial outcomes for the insured members accessing these services. It is also expected to reduce hospital costs and increase patient adherence to treatment for their medical and behavioral conditions. These savings were developed based on other program results, including the IMPACT, Pathways, Missouri Medicaid CMHC Health Homes, and MDDP programs. Below are the savings expected to be produced under our proposal for Medicare and Medicaid:

- Medicare savings during three-year test period = $43.644 million;
- Medicaid savings during three-year test period = $18.655 million; and
- Total Medicare and Medicaid combined = $62.299 million.

Based on the analysis by our actuarial firm, Milliman, the following are the estimated savings to Medicare, Medicaid, and Children's Health Insurance Program (CHIP):

- Medicare savings during three-year test period = $43.644 million;
- Medicaid/CHIP savings during three-year test period = $18.655 million; and
- Total Medicare and Medicaid combined = $62.299 million during 3-year test period.

The projected savings in year four (after the test period) are $31.8 million for Medicare and $12.3 million for Medicaid/CHIP, for a total of $44.1 million in year four. The expected number of Colorado beneficiaries statewide that will be a part of the Colorado SIM, and their projected pre-program costs, post-program costs, and expected program savings PMPM are shown in the following table by Test Year. The savings vary by Test Year due to population mix changes during the years. The PMPM savings times the number of participating beneficiaries, summed across all months of each Test Year equals the total projected savings of the Colorado SIM. The following are the projected beneficiary counts, per capita costs, and per capita savings PMPM for the Medicare and Medicaid population.

Component Summary Table

SIM Component/Project Area: *Payment Reform*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Payers sign Memorandum of Understanding with SIM Office - 12/30/15	• MOU will outline voluntary commitment by participating payers to support value based payments, data aggregation, shared clinical quality metrics, and shared cost and utilization metrics for duration of SIM. • Value based payment approaches will differ by payer	SIM Office; Multi-Payer Collaborative	Payment Reform	MOU signed and submitted to SIM Office by 1/20/16
Payers submit description of payment models that will be used, by category (HCPLAN AMP Framework Draft White Paper) to support SIM practices to the SIM Office as an Addendum to MOU	• Payers have agreed that the alternative payment models used to support SIM participating practices will be consistent with HCPLAN APM Framework Draft White Paper categories 2, 3, and 4, and will provide the SIM Office with a description of the models as an addendum to the MOU • SIM Office and the selected SIM Evaluation Vendor will work with payers to best categorize models that include reimbursement mechanisms that overlap or combine elements of the LAN framework, for tracking and reporting purposes	SIM Office; Multi-Payer Collaborative	Payment Reform	MOU Addendum signed and submitted to SIM Office by 1/20/16; Final categorization of payment models established between Jan - March 2016
Payers identify practices selected to participate in the first SIM cohort that they will support with alternative payment models	• SIM Office will select the practices that will participate in the first cohort in December 2015 • Based on eligible practices that submitted applications and were accepted to participate in the first cohort, payers will provide feedback to the SIM Office regarding practices within their networks eligible to receive value-based payments • Payers will work with practices selected to participate in the first SIM cohort that are in their provider networks or service delivery systems to develop appropriate alternative payment models, and execute payer/practice agreements	SIM Office; Multi-Payer Collaborative	Payment Reform	Payer/practice agreements finalized and executed with all 1st cohort practices, Jan – April 2016

SIM Component/Project Area: *Payment Reform*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Work with CMS to secure Medicare participation in Colorado SIM	• Engage with CMS in ongoing discussions of Medicare participation in SIM • Submit formal proposal to CMS regarding Medicare participation in Colorado SIM • Establish parameters of Medicare support of 1st cohort practices • Determine ongoing relationship between Colorado SIM and potential new federal PCMH models	SIM Office; Multi-Payer Collaborative	Payment Reform	Submit formal proposal to CMS regarding Medicare participation in SIM: 1Q 2016; Establish parameters of Medicare support of 1st cohort practices: 1Q -2Q 2016; Engage in longer term discussions surrounding federal PCHM initiatives: 1Q-4Q 2016
Determine expansion of RISE and Stratus tool licenses to practices participating in first SIM cohort	• SIM Office will work with HCPF and payers to determine the feasibility of expanding the number of licenses available for RISE and the Stratus tool to practices participating in the initial SIM cohort	SIM Office; Multi-Payer Collaborative; SIM Evaluation Specialist	Payment Reform	1Q 2016
Utilize state employee health to expand/drive adoption of integrated care delivery and value-based payments	• SIM Office will continue to work with the Department of Personnel Administration (DPA) regarding the use of contractual language/stipulations regarding integrated care and alternative payment models as part of the state employee health plan re-procurement process	SIM Office; DPA	Payment Reform	Annually

SIM Component/Project Area: *Payment Reform*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Payers determine: 1) whether they can report attributed lives in practice based on 4 LAN framework categories; 2) whether they can report attributed lives in non-SIM participating practices	• Payers will work with their internal informatics teams to determine their capacity for collecting and reporting metrics on attributed lives by payment model • SIM Office and selected SIM Evaluation Vendor will work with payers and CMMI to develop an evaluation framework that is based on data that payers are capable of providing	SIM Office; Multi-Payer Collaborative	Payment Reform	1-Jul-16
Work with payers and informatics teams to determine attribution methodologies that will be utilized for SIM	• Payers will establish attribution methodologies, and mechanisms/capacities for reporting this data to the SIM Office and selected SIM Evaluation Vendor	SIM Office; Multi-Payer Collaborative	Payment Reform	1-Jul-16
Work with payers to define numerators and denominators used for metric reporting	• Payers will work with internal informatics teams, SIM Office, the SIM Evaluation Specialist, and the Selected SIM Evaluation Vendor to define numerators and denominators that will be used for metric reporting • SIM Office will work with CMMI to ensure data being gathered meets the needs of RTI	SIM Office; Multi-Payer Collaborative; SIM Evaluation Specialist; Selected SIM Evaluation Vendor; CMMI	Payment Reform	1-Jul-16
Work with payers to establish baseline data for reported metrics	• Payers will work with internal informatics teams, SIM Office, the SIM Evaluation Specialist, and the Selected SIM Evaluation Vendor to establish a data source and common methodology for establishing baseline data • SIM Office will work with CMMI to ensure data being gathered meets the needs of RTI	SIM Office; Multi-Payer Collaborative; SIM Evaluation Specialist; Selected SIM Evaluation Vendor	Payment Reform	1-Jul-16
Work with payers to set biannual accountability targets for participation in alternative payment models	• Payers will work with internal informatics teams, SIM Office, the SIM Evaluation Specialist, and the Selected SIM Evaluation Vendor to establish biannual accountability targets for the number of lives covered by alternative payment models through SIM • SIM Office will work with CMMI to ensure data being gathered meets the needs of RTI	SIM Office; Multi-Payer Collaborative; SIM Evaluation Specialist; Selected SIM Evaluation Vendor	Payment Reform	1-Jul-16

SIM Component/Project Area: *Payment Reform*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Payers report on the following, two times a year: attributes lives in SIM; practices in SIM	Payers have agreed to report on the number of attributed lives, by payer, and the number of participating practices in SIM	SIM Office; Multi-Payer Collaborative	Payment Reform	Bi-annually
Continue outreach/engagement with self-insured employers, VA, and TRICARE	• SIM Office will engage with the Colorado Business Group on Health, an organization representing 17 self-funded groups from across the state, to explore the expansion of integrated care and alternative payment models to this market segment • SIM Office will also reach out to the VA and TRICARE to explore avenues of involvement with SIM initiatives	SIM Office	Payment Reform	Ongoing
Work with HCPF to align Medicaid payment approaches with SIM initiatives/objectives	• SIM Office will participate in HCPF planning and discussions around proposed payment models for Phase II of the ACC and the CCBHC grant, and other proposed initiatives as they arise	SIM Office	Payment Reform	Ongoing
Work with payers around the selection of practices for SIM cohorts 2 and 3	• SIM Office will engage with the University of Colorado and the payers around selection processes for practice cohorts 2 and 3	SIM Office; University of Colorado; Multi-Payer Collaborative	Payment Reform; Practice Transformation	Ongoing

Leveraging Regulatory Authority

Colorado is committed to developing a policy and regulatory framework that supports the integration of comprehensive primary care and behavioral health services, strengthens population health, and promotes the expansion of value-based payment structures, paving the way for innovation and for reaching our SIM goals and advancing the Triple Aim. By aligning our public and private resources and levers, we intend to drive our markets in a direction that reinforces coherence and coordination. The SIM Office plans to engage with multiple regulatory authorities to advance initiatives in the following domains.

Reinforcing Accountable Care and Delivery System Transformation

Current State

Colorado law specifies the types of health care entities that must be licensed prior to providing services in the state and the requirements for licensure or certification.[40] The Health Facilities and Emergency Medical Services Division (HFEMS) of the CDPHE is tasked with issuing licenses for the operation of health care entities within the state and serves as the designated state agency for inspecting entities that serve Medicare/Medicaid clients in Colorado and making recommendations to CMS regarding certification.[41] The goal of Colorado's health facility licensure and certification requirements is to ensure health care entities meet minimum standards of services and quality in compliance with state law and regulations, and for entities serving Medicare/Medicaid clients, to measure the provider's ability to deliver care that is safe and adequate, in accordance with state and federal law and regulations.

In 1987, the state fully repealed its Certificate of Need laws. While current state statute includes a performance incentive for facilities that cooperate with investigations and are found to have minimal or no deficient practices,[42] Colorado's licensing and certification processes do not contain any requirements or incentives specifically aimed at reducing state healthcare costs or promoting coordinated planning around new services and facility construction.

[40] See Colorado Revised Statutes Sections 25-1.5-103 and 25- 3-101, et. seq.; assisted living residences are also subject to Section 25-27-101, C.R.S., et. seq., home care agencies are subject to Section 25-27.5-101, C.R.S., et seq.

[41] For entities that participate in Medicaid programs but do not serve the Medicare population, HFEMS makes certification recommendations to the Colorado Department of Health Care Policy & Financing (HCPF), rather than CMS.

[42] C.R.S. § 25-3-105(1)(a)(I)(C) - the performance incentive is a 10% reduction of the licensure renewal fee and applies only to the onsite re-licensure survey process

Future actions

Colorado's SIM proposal seeks to bend the cost curve by providing Coloradans with access to integrated primary care and behavioral health, which can better address the health needs of all residents, but particularly those with chronic, co-morbid physical and behavioral health issues. In addition, SIM will link clinical care to public health and other community resources, which will be able to address some of the "upstream" issues that impact health and increase prevention. The utilization of facility licensing requirements as a mechanism for controlling health care costs is somewhat beyond the scope of this framework; however, SIM is engaged with the Colorado Commission on Affordable Health Care, a three-year commission created through bipartisan legislation (SB 14-187), which is charged with analyzing health care costs within the state and making recommendations to the state legislature. The Commission is still outlining the scope of issues and topics it will be addressing, but the SIM office will continue to follow their work, provide comments as appropriate, and ensure SIM initiatives are in alignment with their recommendations.

The variety of community needs assessments currently being conducted by organizations and agencies throughout the state offer an alternative, community-based mechanism that could bring payers and providers together to address local and regional needs, including issues of system capacity. For a complete description of community needs assessment activities in Colorado and SIM's strategies for aligning with and leveraging this work, please see the ***SIM Alignment with State and Federal Initiatives*** section of the Operational Plan.

Improving the Effectiveness and Efficiency of the Health Care Workforce

Current state

Building a healthcare workforce with the capacity, training, efficiency, and effectiveness to support the Colorado Framework integrated care model will be a critical component of SIM's success. Colorado faces challenges in transforming its health care workforce. While the overall size of the workforce is appropriate by many measures, rural and frontier regions face ongoing shortages of both primary care and behavioral health providers. In addition, Colorado has a deficit of providers in specific behavioral health specialty areas, including psychiatry and professionals with specific expertise in treating children.

Integrated care, the foundational element of Colorado SIM, requires a different set of skills, knowledge, and attitudes than the skill set required to work in traditional models. Most primary and behavioral health providers are not trained to provide integrated, team-based care and may not have the correct competencies. To transform *today's* primary care and behavioral health workforce, current providers

will need training and ongoing support to successfully work in a system of integrated care that truly addresses the patient's needs. Training *tomorrow's* workforce to operate successfully in integrated, team-based care settings requires further attention to the education, training, and residency approaches in Colorado.

Colorado boasts a long legacy of thoughtful and low-burden regulation to achieve public health priorities. Colorado is one of several states to utilize an umbrella structure, which houses nearly all licensing regulations for healthcare providers under a single agency, DORA. This shared-services model keeps licensing costs low and facilitates collaboration among autonomous licensing boards. SIM will work with DORA to leverage this model as a foundation upon which to build a team-based healthcare workforce responsive to tomorrow's patient needs.

Future actions

The SIM Office will work with and across state regulatory agencies to ensure that Colorado's legislative and regulatory infrastructure supports sustainable, long-term integrated care models. Key partners, which include: the Division of Professions and Occupations at the Colorado DORA, which regulates more than 50 professions, occupations, and businesses within the state; the Health Equity and Access Branch of the CDPHE, which addresses health care workforce, planning, and prevention needs in underserved communities; the Colorado Association of Local Public Health Officials (CALPHO), which is the statewide organization representing LPHAs in Colorado; the Colorado Behavioral Healthcare Transformation Council within the CDHS, which addresses issues related to the behavioral health workforce; the Department of Labor and Employment's Colorado Workforce Development Council (CWDC); the Colorado Public Health Association; the Department of CDHCPF; and professional guilds and provider associations.

During the planning process for the SIM grant, several barriers were identified in the current regulatory structures, which inhibit collaboration among providers, particularly at the financial and operational levels. Statutory provisions regulate providers without reference to their collaboration with other professionals, and regulations differ significantly among professions, even if they provide similar services to patients. In some circumstances, professional regulation differs by the type of facility in which one practices, causing unnecessary confusion. Current law does not clearly provide the authority to create new facility types that may be necessary for, or help facilitate, integrated care. Separate authorities for licensing, payment, and compliance of the physical structure often serve to preclude creativity in the delivery of care, and instead promotes "siloed" decision-making by facility type.

Colorado SIM will conduct a review of current statutory and regulatory structures and work with the organizations listed above to address barriers and workplace administrative inefficiencies and promote the development of an oversight structure that facilitates the delivery of team-based care in which all practice members – including primary care clinicians, behavioral health providers, care coordinators, CHWs, other non-licensed providers, and non-medical staff – are working collaboratively, at the top of their licensure and/or scope of practice, to meet the needs of their practice population. SIM will also explore mechanisms for strengthening Colorado's workforce pipeline by developing and/or expanding provider education and training, and creating additional academic collaborations and programs that support the education of primary care and behavioral health care providers in preparation to work and thrive in an integrated environment. To address provider shortage issues, both now and in the future, SIM will explore legislative options, such as loan payment programs, that incent providers to pursue certain occupations, or practice in high needs areas of the state.

Aligning State Regulations to Support SIM Model Components

Payment Reform

Current state

Commercial Insurance

The Colorado DOI, within the Colorado DORA, is the primary regulator of health insurance carriers operating in the state. Insurance regulation in the state is structured around several key functions, including company licensing, producer licensing, product regulation, market conduct, financial regulation, and consumer services. The DOI's regulatory role varies across different insurance market segments, but consistently includes four major responsibilities: rate regulation; consumer protection; financial solvency; and market regulation.

The DOI is charged with reviewing proposed new premium rates to ensure such rates are not excessive, inadequate, or unfairly discriminatory, and reviewing plan benefits to ensure companies follow Colorado and federal laws. Rate standards are included in state laws and are the foundation for the acceptance, denial or adjustment to rate filings. In 2011, Colorado was designated as an "effective rate review state" by CMS, meaning the DOI has both the resources and authority to conduct rate reviews.[43] In 2013, HB 13-1266, the "Alignment Bill," was signed into law, bringing Colorado's health insurance statutes into

[43] Although the federal threshold for triggering a rate review is set at increases of 10% or more, the Colorado DOI reviews all proposed rate increases.

alignment with the health insurance market reforms mandated by the Patient Protection and Affordable Care Act.

In addition to reviewing rates and health benefit plan submissions, the DOI is also responsible for ensuring the all managed care commercial plans maintain an adequate network of providers, defined as "a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay."[44] For individual and small group plans, the Division also reviews the number and type of Essential Community Providers (ECPs) that are included in carrier networks. The responsibility for designating entities as ECPs lies with CDHCPF. The DOI and HCP work collaboratively to maintain a current list of ECP providers within the state. CDPHE has statutory responsibility for ensuring the adequacy of networks offered by health maintenance organizations.

A third key function of the DOI is financial regulation and ensuring that carriers have sufficient resources to pay claims. The DOI examines health insurance carriers' quarterly and annual financial statements as part of the rate review process, and conducts periodic financial examinations a scheduled basis. The DOI has the authority to assume control of companies found to be financially impaired, and works with them to establish a path to financial health. In the event the company must be liquidated or becomes insolvent, the state maintains a system of financial guaranty funds that cover consumers' personal losses.

Medicaid

Colorado Medicaid's ACC program divides the state into seven RCCOs, which are responsible for developing a network of providers, supporting providers with coaching and information, managing and coordinating member care, connecting members with non-medical services, and reporting on costs, utilization, and outcomes. ACC enrollees are connected to primary care providers (primary care medical providers, or PCMPs) who are contracted with RCCOs and serve as the enrollee's medical home. Services are reimbursed on a fee-for-service basis, but PCMPs and RCCOs both receive an additional per-member, per-month payment designed to help implement the infrastructure that will help coordinate care within and among practices. In addition, PCMPs and RCCOs receive payments for meeting certain Key Performance Indicators (KPIs). Finally, PCMPs can receive additional enhanced payments if they meet additional factors and are designated by the RCCO as an enhanced PCMP.

[44] C.R.S., 10-16-704

Medicaid clients currently receive behavioral health services through a system of Behavioral Health Organizations (BHOs), which are responsible for arranging or providing for medically necessary mental health and SUD services to members in their geographic region. As currently structured, the BHOs are contracted to cover Medicaid clients with a covered behavioral health diagnosis, and services are reimbursed through a fully capitated behavioral health carve-out financed by a 1915(b) Managed Care waiver. The BHOs are paid a PMPM rate to cover the full range of behavioral health services for their population. Some substance abuse services (inpatient and adult residential) are not included in the capitated payment and are funded through the SAMHSA block grant, distributed through the OBH.

Coordination of services in support of integration is currently a contract requirement for both BHOs and RCCOs. RCCOs and BHOs strive for "whole person care" by focusing on care coordination; bi-directional referrals; screening for major issues that fall under either provider; sharing information to coordinate care; alignment of some quality and performance measures such as reduction of ER visits, hospital readmissions, and increase in follow-up care; co-location; tele-psychiatry; and sharing data. Data sharing is mainly achieved through the Statewide Data Analytics Contractor (SDAC), a HIT contractor that analyzes and reports on claims data and provides PCMPs, RCCOs, and CDHCPF with actionable data at the client and population level. Client-level data is used to support care management activities, and can help RCCOs and PCMPs identify clients with many medical needs. Population-level data is used to evaluate and improve the performance of RCCOs, PCMPs, and the program overall.

CDHCPF committed to several new strategies in FY 2015-2016 to strengthen the ACC. Building off the foundation of primary care and medical homes, CDHCPF is developing its infrastructure to create "medical neighborhoods" that include access to specialist care, hospital care, and self-management at home. Within the construct of the medical neighborhood model, PCMPs work with specialists to use limited specialist resources in the most efficient and effective ways possible. Medical neighborhoods offer a more sophisticated form or care coordination by linking local medical and non-medical resources together into flexible, local systems of care that can meet the diverse needs of Medicaid clients.

Future actions

Colorado SIM will build upon public and private payers' commitments, demonstrated though both individual initiatives and joint participation in CPCI, to develop and implement alternative payment models and ultimately move toward prospective, non-volume based payments. The MPC offers a unique forum for voluntary collaboration and alignment of the state's major payers around transformation activities, including the provision of enhanced financial, technical, and data support to practices. As

noted in the “Payment and/or Service Delivery Model” section of the Operational Plan, SIM has used the CPCI as foundation in designing several components of the initiative: 1) CQMs – the majority of measures in the SIM minimum dataset are already being collected under CPCI, minimizing the burden on payers and practices; 2) the CPCI milestones were adopted into SIM Building Block framework for practice transformation; and 3) the Rise database and Stratus tool will be leveraged and expanded under SIM.

To date, commercial payer commitments to pursuing alternative payment models have been entirely voluntary; the ten members of the MPC (including nine private payers and Medicaid) have pledged continued cooperation under SIM. Colorado SIM’s approach to payment reform is not prescriptive, in that it does not require or promote the use of specific payment strategies, such as bundled payments or episodes of care. Rather, SIM recognizes that payers and providers will be at different stages of readiness, and therefore allows both entities to enter progress down a glide path, from arrangements including fee-for-service and care coordination to shared savings/shared risk models, and ultimately to prospective, outcome-based payments based on patient populations.

Current Colorado statutes and regulations neither prohibit nor encourage alternative based payments or the use of value-based insurance designs. As these models develop and become more sophisticated under SIM, including the assumption of down-side risk, SIM will work with the DOI to ensure the proper regulatory protections are in place to guard against over-extended risk, insufficient pooling, and market failure. In addition, as best practices are identified over the course of the model test, SIM will explore the use of state regulations or guidance that could accelerate the adoption of successful approaches.

ACC Phase II and RCCO Rebid

In October 2015, CDHCPF released the “ACC Phase II Concept Paper,” which outlines a series of proposed changes to the ACC program. The agency is seeking to capitalize on the opportunity presented by the re-procurement process for the RCCO contracts, which are set to expire in 2017. While CDHCPF will engage in extensive stakeholder discussions over the next several months to refine the vision and purpose of the ACC, proposed changes Medicaid’s current payment structure which have potential cross-over with SIM include:

- A single administrative entity, called a Regional Accountable Entity (RAE), will assume the responsibilities formerly divided between the RCCOs and BHOs;

- A greater proportion of the administrative PMPM paid to RAEs and providers will be tied to value and outcomes;
- RAEs will be paid incentive payments based on KPIs on nine measures across three core outcome domains: improved health, more value, and better experience;
- Competitive pools will be used to drive innovation in high-needs areas or areas in which the program has not been successful;
- A shared savings program will be implemented as a short-term strategy to incent RAEs to control costs and reduce expenditures; and
- Reimbursement of behavioral health services will move from the current capitated system to managed fee-for-service arrangements (or encounter based payments for CMHCs and FQHCs).

Physical and behavioral health integration may be supported through the following actions: 1) removing the covered diagnosis requirement for behavioral health services; 2) finding a mechanism to reimburse visits that include physical and behavioral health services; 3) identifying ways to overcome barriers to integration, including time-based procedure codes, and ensuring reimbursement is sufficient for the service provided; and 4) reimbursing multiple and new provider types for low acuity behavioral services.

The shift from capitation to fee-for-service for behavioral health benefits represents a significant departure from the current payment environment for behavioral health, which was established in 1995 and later expanded statewide in response to rising Medicaid costs for behavioral health. Such a move would bring the financing of physical and behavioral health benefits under a single framework and address a key issue of payment fragmentation within the current system. The implications of moving back on the payment reform glide path from capitation to fee-for-service are the focus of considerable conversation and stakeholder input underway in Colorado. The proposed reimbursement structure would allow for some potential utilization and outcome-oriented elements, including quality metrics, incentive payments, and shared savings arrangements. Another important element of the ACC Phase II proposal is to increase collaborative care that takes place beyond the walls of the PCMP office through the creation of Health Neighborhoods, which will include specialists, hospitals, oral health providers, and other ancillary providers. To date, CDHCPF has already started moving toward value-based payments for hospital inpatient and outpatient reimbursements, through the use of All Patient Refined Diagnosis Related Groupers (DRGs) [for Hospital Acquired Conditions, Potentially Preventable Conditions, Potentially Preventable Readmissions, and clinical and/or demographic risk factors], and Enhanced

Ambulatory Patient Groupings. CDHCPF is also exploring, in conjunction with SIM, the possibility of a Delivery System Reform Incentive Program (DSRIP) to promote innovation and efficiency in hospital (and potentially other) services.

The timing of the RCOO re-bid and ACC restructuring offers a unique opportunity for collaboration between Medicaid and the SIM initiative. CDHCPF structured many elements of the proposed ACC reorganization, particularly around the integration of physical and behavioral health to align with SIM goals and objectives and with other initiatives in the state. The SIM Office will continue to work with HCPF as the ACC Phase II proposal evolves over the next several months, to ensure continued coordination around approaches to care delivery and payment reform.

Care Delivery Transformation

Current state

The integration of primary care and behavioral health forms the cornerstone of Colorado's SIM transformation efforts. One of the key barriers to SIM's goal of providing 80 percent of Coloradans with access to integrate care delivery systems is the fragmented nature of the current regulatory and oversight structure for physical, mental health, and substance use providers and programs. Complex and sometimes contradictory rules governing physical and behavioral health result in disjointed systems of care, and lead to confusion and/or perceived burden by providers, poor care and poor patient outcomes, and substantial inefficiency, ineffectiveness, and waste within the current system. Most insurers in Colorado administer and pay for behavioral health care benefits separately from physical health care, perpetuating multi-level fragmentation in the healthcare system. In addition, the lack of systematic coordination clinical and public health delivery systems and social services providers makes care coordination across entities difficult, if not impossible.

A multi-disciplinary group of stakeholders, convened in the summer of 2014 jointly by the CDHCPF, the CDPHE, and the CDHS assessed regulatory and administrative barriers to integrated care in the state and released the following findings:

- Differences in department rules are often rooted in different goals or regulatory purposes (i.e., variations in department mission, statutory requirements, or federal funding or requirements);
- In some instances, variation or duplication between department rules is the result of individualized and siloed approaches to rule creation (i.e., an agency creates a rule to solve a

specific need, but fails to consider how that rule may relate to or overlap with another agency's rules); and

- In addition to identifying several rules that may pose a barrier to integrated care, the group identified several non-rule barriers, including: differing payment structures and philosophies; a disease-based model of care that requires a diagnosis in order to receive behavioral health benefits; and operational barriers, such as pre-authorization, utilization review, and medical necessity, are not uniformly applied to behavioral health benefits.

Future actions

The SIM initiative offers an extended forum for bringing state agencies and other stakeholders together to address regulatory and other barriers to integrated care within the state. Staff from various state agencies are represented on all of the SIM Workgroups, and the SIM Policy and Workforce Workgroups both explicitly reference identify regulatory barriers to integrated care delivery in their charters.

Colorado SIM is committed to updating the state's legal and regulatory framework to address population-wide needs, and streamlining administrative infrastructures to better serve Coloradans. Such actions align with Governor Hickenlooper's commitment to make state government more efficient, effective and elegant.

The policy and regulatory levers we will utilize, and the specific actions we will take, are outlined in the remainder of this section and in the Component Table. In the initial SIM application, Colorado indicated that it would be pursuing a State Plan Amendment for a Section 2703 health home. Since that time, Colorado Medicaid has continued to pursue significant transformation of the health care delivery system through the ACC model. The Department is currently working on furthering integrated care through the current ACC program design and as the Department builds toward the launch of the second phase of the program in July 2017. The Department is beginning conversations with CMS about the federal authorities needed to support the evolution of the ACC in Colorado. These conversations will include an exploration of a variety of authorities and may include evaluation of amendments to the state plan for Section2703 health homes, although that is not certain.

Population Health

Current State

Public health services in Colorado are provided through the CDPHE and 54 LPHAs that operate separately and 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 which direct the State Board of Health to establish core public health services and minimum quality standards for public health agencies. In addition to governmental public health, Colorado has numerous community-based organizations that work in the public health and prevention arenas. Partnerships among public health agencies, community-based organizations, safety net providers and other organizations are growing increasingly important as Colorado takes more of a "social determinants of health" approach to health improvement.

Future Actions

Colorado SIM will work with stakeholder partners to create coordinated systems of care that connect the disparate elements of the health care continuum in a patient-centered system that links direct care delivery with public health and community resources. SIM seeks to leverage the potential population-based prevention impact that the public health system can bring to the rest of the care delivery system by pursing multiple policy initiatives.

Coordinating and Aligning with other State Policy Agendas

SIM will work with state and LPHAs and other stakeholder organizations to jointly advance regulatory issues that improve population health and address regulatory barriers in areas such as obesity, behavioral health, tobacco access and pricing, food access, diabetes, and environmental safety and activity measures. SIM will partner with the CDPHE to achieve the policy objectives outlined in the *Healthy Colorado: Shaping a State of Health- Colorado's Plan for Improving Public Health and the Environment 2015-2019* report, discussed in the ***Plan for Improving Population Health*** section, and the CDHS Office of Early Childhood's *2015 Early Childhood Mental Health Strategic Plan* discussed under the ***SIM Alignment with State and Federal Initiatives*** section of the Operational Plan.

Specific regulatory actions may include working to eliminate limits on the ability of local jurisdictions to regulate tobacco sales and prices, and extending recent successes Colorado's Plan to Reduce Prescription Drug Abuse and a regulatory structure for legalized adult-use marijuana that focuses investments on treatment, enforcement, education and research.

Reimbursement of public health services and functions

In addition, Colorado SIM will work to expand outcomes-based reimbursement mechanisms to include public health services. Currently, public health receives much of its funding through unsustainable, project-based grants. When public health agencies are able to bill insurers for specific services,

reimbursement for services provided in a public health setting is often substantially lower than it would be in a traditional care delivery setting. SIM will work with payers and the DOI to explore options around including LPHAs in provider networks and the reimbursement levels of services provided by public health entities. Solutions may include a range of actions, including increased education of payers and LPHAs about the types of services provided, and the need for reimbursement; voluntary cooperation among payers around the integration of LPHAs in payment models; and potential amendments to network adequacy or other state regulations.

Innovation in the delivery of health care in Colorado presents an opportunity for LPHAs and other community-based organizations to provide population-based services with the long-term potential for reimbursement. Colorado SIM will continue existing partnerships that support alignment between private and public payment strategies and public health initiatives, to ensure coordinate community systems of care are sustainable in the future.

Health Information Technology

A detailed description of policy and regulatory actions that will be utilized to support and advance SIM's HIT goals and objectives can be found in the HIT section of the Operational Plan.

Integrating Value-Based Principles in Health Insurance Plans

Qualified Health Plan Certification

Colorado DOI has regulatory authority over QHPs, and works with Connect for Health Colorado (C4HCO), the Exchange), Colorado's health care insurance marketplace, to certify individual and small group health plans sold through the Exchange. Connect for Health is an independent non-profit organization, established through bipartisan legislation, and is prohibited by statute from "duplicating or replacing" the duties of the Insurance Commissioner or engaging in any form of "active purchasing," and functions primarily as a distribution channel for insurance products. The DOI maintains regulatory authority over the health insurance marketplace, and reviews all submitted QHP filings to ensure compliance with state and federal laws (i.e., rating requirements, non-discrimination provisions, coverage of Essential Health Benefits, etc.). For QHPs that are offered on the Exchange, C4HCO is responsible for additionally ensuring that participating carriers are accredited, and are licensed and in good standing to do business in the state. The DOI applies the same set of review standards, whenever possible, to plans on or off the Exchange; therefore, reforms and innovations achieved through SIM will reach all plan in the individual and small group markets.

The SIM Office has engaged in discussions with C4HCO and the DOI to explore the use of QHP certification requirements as a mechanism to promote and support SIM objectives around integrated care and alternative payment models. Both entities have tentatively agreed to expand the ACA's Quality Improvement Strategy (QIS) reporting requirements[45] to include data elements regarding integrated care and value-based payments. Utilizing a document that will already be part of required plan submissions for the 2017 plan year will minimize the reporting burden on carriers, and the reviewing burden on DOI regulators. Standardizing the form and type of information that must be reported will also allow for a more meaningful comparison between carriers, and will help maintain a level-playing field in the marketplace.

The SIM Office, in conjunction with C4HC and the DOI, is currently working to develop specific language that will be included in the QIS documentation, to best capture the degree of care integration within the carrier's networks and the extent to which value-based payments are being utilized. Carriers will be asked to file this information as part of their 2017 plan filings. For the 2017 plan year, the information will be for reporting purposes only and will not impact certification decisions. The SIM Office will work with the DOI and C4HC in subsequent years to determine if/when/how this requirement could be incorporated into the certification process (i.e., developing thresholds regarding care delivery and payment models that must be met in order for the plan to be sold). In addition, SIM is working the C4HC to develop a "rating system" for plans offered through the Exchange, in which plans that offer integrated care delivery and/or employ alternative payment models receive some sort of visual designation (i.e., a gold star) on the C4HC website.

State Employee Health Plan

The Department of Personnel & Administration (DPA) has agreed to support the SIM initiative by including contractual requirements around the availability of integrated care and the use of alternative payment models in the upcoming re-procurement process for the State Employee Health Plan, scheduled for 2016. This will extend SIM's reach to the roughly 30,000 state employees and dependents currently receiving coverage through a self-funded plan administered by UnitedHealthcare and a fully insured Kaiser Permanente product. SIM is also working with the DPA regarding participation in the SIM

[45] Per federal regulation, carriers offering qualified health plans (QHPs) in an Exchange for at least 2 years must implement and begin reporting on information regarding a QIS, in which they identify the health outcome needs of their enrollees, set goals for improvement, and provide certain incentives for providers to achieve those goals. Although a carrier's QIS plan must address certain statutorily-defined health care topic areas (outlined in Section 1311(g)(1) of the Affordable Care Act), as a State-Based Marketplace (SBM), Colorado maintains a degree of flexibility in designing and implementing QIS reporting requirements.

minimum dataset, the inclusion of state employee data in data aggregation, and the use of consumer engagement tools.

The State of Colorado will begin contract renewal discussions with its two carriers in the spring with a required effective date of July 1, 2016. Building on the work already underway, the State will explore a variety of alternatives to further achievement of SIM goals including: development/refinement of performance measures with a foundation in best practices for coordinated care, alternate pay models addressing both population and episode specific outcomes, and strategies for consumer engagement.

Network Adequacy/Provider Contracting

Current state

In Colorado, three agencies are responsible for monitoring the "adequacy" of health plan provider networks to ensure policyholders have access to care that will meet their health needs. In the commercial market, the DOI regulates plans with managed care networks, while CDPHE has authority over health maintenance organizations. Colorado statutes regarding network adequacy for commercial plans are largely based on the National Association of Insurance Commissioner's Managed Care Network Adequacy Model Act. This Act is currently being revised, and a final document is expected to be approved in the coming months. The DOI will likely seek to update Colorado statutes to reflect these changes.

Current state law outlines criteria that can be used to assess network adequacy, but does not include a set of specific standards (i.e., networks must include an adequate number of accessible primary care providers, specialists and subspecialists, and acute care hospital services, but actual metrics – such as a provider to enrollee ratios – are not defined). Since 2014, the DOI has been collecting information about individual and small group health provider networks through plan filing submissions, as a means to collect data on current practices in Colorado. The DOI is using this information as a baseline to develop specific network adequacy standards and reporting requirements, including the inclusion of Essential Community Providers.[46] As part of this process, the DOI will be holding a series of stakeholder meetings this fall, and potentially setting standards and reporting requirements for the 2017 plan year.

[46] Essential community providers are broadly defined health care providers that serve high-risk, special needs, and underserved individuals. The ACA established specific requirements for individual and small group plans to include ECPs within provider networks; as a state-based exchange, Colorado has autonomy to set a required "threshold" (i.e., provider networks must include 15% of the ECPs within a plan's service area).

In Medicaid, RCCOs are responsible for creating and maintaining provider networks, and following federal Medicaid network adequacy standards. Under the ACC, CDHCPF sought to have broad provider networks, so current PCMPs must meet minimal standards to participate. However, the proposed ACC restructuring will allow the use of more stringent network criteria. Providers will need to meet a set of minimum requirements, but under the proposed Phase II of the ACC, RAEs, the organizations that will be responsible for coordinating care in various regions in the state, will have greater latitude to limit networks to high-performing practices that can provide culturally competent care to care various populations, including the disabled.[47]

Future actions

Colorado SIM will closely monitor proposed changes to state network adequacy statutes, and take part in the DOI's stakeholder meetings regarding the establishment of network standards. Requirements related to the inclusion of behavioral health professionals and ECPs in provider networks have the potential to support integrated care delivery models, by ensuring that payers maintain an adequate number of providers to deliver such care. However, Colorado does not have an "any willing provider" statute, and carriers are allowed to develop their own inclusion criteria for provide participation in their networks. As part of the commercial plan network adequacy review, Colorado currently reviews the inclusion of ECPs within provider networks, and in the course of adopting the National Association of Insurance Commissioners (NAIC) model will establish standards to ensure low-income, medically underserved individuals have access to needed providers and services.

Colorado law does not restrict a carrier's ability to contract with high-quality providers, but it also does not require them to do so. In the absence of compelling concerns about public safety and/or public interest, Colorado policy makers have traditionally been reluctant to increase the regulatory burden on businesses in the state. Colorado SIM therefore initially will promote transparency around carrier's actions to incorporate integrated care and alternative payment models into their plans by working with the DOI to add questions regarding these activities into carriers' QIS reporting requirements, as outlined above. We also will engage in a larger discussion with the DOI, C4HC, and carriers about making integrated care delivery and the utilization of alternative payment models requirements for QHP certification process, as described above.

[47] Colorado Department of Health Care Policy and Financing. (October 20, 2015). *Accountable Care Collaborative Phase II Concept Paper.*

The standards that define an adequate network must take into account the number and distribution health care professionals in the state. Setting a provider-to-enrollee ratio that is unattainable due to a shortage of providers in a specific area will not improve access to care. SIM activities related to the collection of accurate, aggregate data on the state's workforce, and efforts to bolster the workforce pipeline, will be a critical source of data for the state in moving forward on network adequacy standards.

Over the course of the Model Test, SIM will work to coordinate network adequacy standards across the DOI, CDPHE, and CDHCPF, to ensure that all state residents, regardless of payer source, have access to the care they need.

Integrating Transformation-Based Teachings into Medical Education Programs

Colorado has a robust academic training environment of Colorado-based universities, colleges, and educational institutions, with two medical schools, a school of public health, two physician assistant programs, seven doctoral psychology programs, four schools offering Master of Social Work degrees, and numerous additional programs in nursing and other professions that add to the capacity of the primary care team across the state. Many schools have already developed special training programs or initiatives to support team-based primary care, behavioral health integration, and interdisciplinary training of health professionals. Academic institutions have also engaged with other key stakeholders to address workforce training needs – for both the present and future workforce – in a variety of activities, including participation in the CWDC[48], the National Governor's Association (NGA) Health Workforce Policy Academy *Building a Transformed Health Care Workforce: Moving from Planning to Implementation*.

Colorado SIM will build on ongoing workforce development and planning efforts in the state, including activities related to training, and provide a forum for continued collaboration and coordination of these initiatives. SIM will also take a leadership role identifying and developing programs to address workforce training needs as they relate to the provision of integrated physical and behavioral healthcare. As part of this effort, the Colorado SIM Office supported and participated in the recent Colorado Consensus Conference, which brought Colorado-based universities, colleges, and educational institutions together to develop minimal standards/competencies for behavioral health providers working in primary care. The key competencies identified during the summit will be synthesized into a report that can be

[48] The CDWC was created by the federal Workforce and Investment Act of 1998, and is the state's designated organization for overseeing Workforce Investment Act funds; in addition, the CDWC advises the Governor and state legislature on policy matters related to the Workforce Investment Act, and is responsible for ensuring continuous improvement of the state's workforce system.

adopted statewide and acted upon by various stakeholders in multiple settings (e.g. universities, SIM leaders).

For a complete description of planned SIM workforce initiatives, please see the section of the Operational Plan titled "Workforce Capacity."

Additional Colorado Policy and Regulatory Initiatives

Colorado will be pursuing a comprehensive policy strategy, which aligns with and advances the health policy agenda set forth in Governor Hickenlooper's State of Health, to achieve SIM's goals and objectives. A detailed listing of planned policy activities is listed in the Component Table. An additional description of policy initiatives in the areas of Workforce and HIT can be found in their respective sections of the Operational Plan.

Component Summary Table

SIM Component/Project Area: *Leveraging Regulatory Authority*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Overarching Objectives				
Engage with state agencies, individually and collectively, around the development of legislative agendas	• Use SIM Policy Workgroup as a forum to discussion current and future legislation, generate legislative proposals/strategies • SIM Policy Analyst will meet with the legislative leads of state agencies periodically to discuss legislative agendas/potential legislative actions	SIM Office	Practice Transformation; Payment Reform; Population Health; HIT	Develop and advance a unified legislative agenda around SIM goals and objectives
Coordinate and consolidate regulatory oversight functions among state agencies	• Address the fragmented oversight of physical/mental/substance use providers and programs by: - Developing strategies/processes to increase coordination among state departments regarding strategic goals around health and health care - Identifying mechanisms to overcome individual approaches to rule creation to reduce variation, duplication, and/or conflict	SIM Office: State Agencies	Practice Transformation; Payment Reform; Population Health; HIT	Reduce or eliminate overlapping, duplicative, or conflicting regulations or functions; streamline program administration and oversight
Identify non-rule barriers to integrated care and payment reform, and recommend policy solutions	• Examine issues including: - Differing payment structures and philosophies - Disease-based model of care - Operational barriers, such as pre-authorization, utilization review, and medical necessity, are not uniformly applied to behavioral health benefits	SIM Office; Stakeholders	Practice Transformation; Payment Reform; Population Health; HIT	Remove current structural barriers to integrated care and payment reform
Evaluate findings from 187 Cost Containment Commission and integrate/align recommendations with SIM initiatives	• Attend Commission meetings and offer comments as appropriate • Review issued findings/reports • Identify areas of articulation, and opportunities for collaboration around shared priorities/goals	SIM Office	Practice Transformation; Payment Reform	Align and integrated Cost Commission principles, recommendations, actions with SIM
Identify and implement policy actions that will advance statewide health information sharing	• Evaluate policy actions, such as: - Subscription subsidies to health technology platforms - Improving a patient centric approach to data sharing across public and private care settings	SIM Office	HIT	Increase/advance/improve statewide health information sharing through the use of various policy levers

SIM Component/Project Area: *Leveraging Regulatory Authority*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Wellness, Community Engagement, and Patient Protection				
Patient access to health records	• Review & identify rules that may create barriers to patients' ability to access health records • Work with Consumer Engagement Workgroup to identify specific issues around patient/consumer access • Facilitate discussion and develop recommendations	SIM Office; Policy Workgroup; Consumer Engagement Workgroup	Practice Transformation; HIT	Establish consensus-based policies/rules/standards regarding patient access to health records
Price transparency	Assess and recommend improvements to laws and rules related to price transparency for health care services	SIM Office; Policy Workgroup	Practice Transformation; Payment Reform	Make recommendations regarding price transparency requirements
Confidentiality of minor's records	Reconcile rule conflict related to the requirement for insurance providers to send an Explanation of Benefits to policy holders for confidential, sensitive health care provided to minors	SIM Office; Policy Workgroup	Practice Transformation; HIT	Work with DORA and stakeholders to develop solutions
Preventive services administration and funding	Coordinate and align administration and funding of prevention services	SIM Office; Policy Workgroup	Population Health; Payment Reform	Support delivery of preventive service through coordination/alignment of funding and administration
Work with state and local public health agencies and other organizations to jointly advance regulatory issues that improve population health	• Address regulatory barriers in areas such as obesity, behavioral health, tobacco access and pricing, food access, diabetes, and environmental safety and activity measures • Work to eliminate limits on the ability of local jurisdictions to regulate tobacco sales and prices • Partner with CDPHE to implement/achieve policy objectives outlined in the *Healthy Colorado: Shaping a State of Health- Colorado's Plan for Improving Public Health and the Environment 2015-2019* report • Partner with CDHS to implement/achieve policy objectives outlined in the Office of Early Childhood's *2015 Early Childhood Mental Health Strategic Plan*	SIM Office; Policy Workgroup	Population Health	Coordinate and align policies and regulations that improve/support population health at state and local level
Workforce and Access to Care				

SIM Component/Project Area: *Leveraging Regulatory Authority*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Work with DORA and other stakeholder partners to identify and implement administrative improvements to health professionals licensing process	• Secure multistate licensure reciprocity for key health professions • Review and make recommendations regarding the Interstate Medical Licensure Compact	SIM Office; Policy Workgroup	Practice Transformation	Improved health professional licensing process
Address scope of practice laws, credentialing and/or licensing to accommodate changing workforce	Examine competencies/roles/reimbursement structures for licensed and non-licensed professions, including but not limited to: CHW, PNs, paramedicine, nursing supervision hours requirement, state mandated CMEs	SIM Office; Policy Workgroup	Practice Transformation	Current and future workforce has skills/competencies and ability to function effectively in team-based, integrated care environment
Review identified regulatory barriers to integrated care delivery, and propose recommended solutions	• Work with HCPF and OBH/CDHS to align or coordinate timeframes for quality reviews and assessments • Review/clarify OBH/CDHS regulations regarding licensure of site/practice for substance use disorder services, and the circumstances in under which a licensed physical health provider practice requires additional licensure to provide SUD services • Work with CDPHE and the Department of Public Safety to reconcile/streamline life and safety codes across health care providers (remove differences based on the type of health care provided, including the additional standards for behavioral health) • Address statutory provisions that regulate providers without reference to collaboration with other professions, and differences in regulations by profession when providers offer similar services to patients	SIM Office; Policy Workgroup	Practice Transformation	Develop regulatory framework that supports integrated care delivery

SIM Component/Project Area: *Leveraging Regulatory Authority*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Identify policy mechanisms for expanding current and future workforce training to deliver care in an integrated setting	• Develop and/or expand provider education and training, by fostering additional academic collaborations and programs • Expand provider cultural sensitivity training, particularly in relation to special populations, such as the DD/IDD population • Work with stakeholder partners to identify and disseminate core competencies around integrated care delivery for primary care and behavioral health care providers • Use SIM as a platform to coordinate a statewide campaign to educate/inform providers on incorporating behavioral health specialists into primary care practices • Leverage the Health Extension System to connect providers to training resources	SIM Office; Policy Workgroup	Practice Transformation	Develop current and future workforce capable of providing 80% of Coloradans with access to integrated physical and behavioral health care
Identify areas where new regulations for providers/facilities are required	• Determine authority needed to create new facility types that may be necessary for, or help facilitate, integrated care	SIM Office; Policy Workgroup	Practice Transformation	Remove current structural barriers to integrated care
Explore legislative/regulatory actions to strengthen Colorado's workforce pipeline	• Protect and potentially expand funding for health professions loan repayment programs supporting workforce statewide	SIM Office; Policy Workgroup	Practice Transformation	Develop current and future workforce capable of providing 80% of Coloradans with access to integrated physical and behavioral health care
Data collection on the primary care and behavioral health workforce	• Utilize multiple data sources to obtain information about primary care physicians, advanced practice nurses, pharmacists, and other providers in the state	SIM Office; Policy Workgroup	Practice Transformation	Develop database of information regarding the type and distribution of health care providers in the state
Care Delivery and Service & System Integration				
Clarify barriers around information sharing between providers, privacy and confidentiality, and consent	• Provide State-endorsed guidance regarding Personal Health Information privacy and confidentiality rules under HIPAA, 42 CFT Part 2, and Colorado law • Develop and pilot a standardized consent form • Develop education and training materials for providers and consumers around privacy and confidentiality law and consent requirements	SIM Office; Policy Workgroup	Practice Transformation; HIT	Create legal framework that allows the exchange of patient health information while maintaining patient confidentiality/protections

SIM Component/Project Area: *Leveraging Regulatory Authority*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Address barriers related to the full implementation of mental health parity	• Review identified barriers, including but not limited to: - Differences in privacy protections - Different billing systems and requirements - Different phone numbers at insurance companies for questions or pre-authorizations between physical health and behavioral health benefits	SIM Office; Policy Workgroup	Practice Transformation	Ensure mental health parity requirements are properly understood (by patient, providers, insurers) and health plans are in compliance with state law
Examine state regulations, such as building codes or licensing requirements that may create a barrier for the integration of behavioral and physical health	• Work with state agencies to review regulations • Make recommendations regarding changes, amendments	SIM Office; Policy Workgroup	Practice Transformation	Remove structural and/or regulatory barriers to integrated care
Examine state requirements for commercial insurance that may impede or facilitate integrated care	• Explore the use of QHP certification requirements as a mechanism to promote/support integrated care and value based payments; options include the expansion of the ACA's QIS reporting requirements to include data elements regarding integrated care and value-based payments • Work with DOI as network adequacy standards are updated, and examine possible requirements/guidance around the inclusion of behavioral health providers • Work with DOI, HCPF, and CDPHE to coordinate/align network adequacy standards, as possible	SIM Office; Policy Workgroup	Practice Transformation	Utilize policy levers to advance SIM goals and objectives regarding integrated care delivery
Leverage the state employee health as a mechanism for expanding/driving the adoption of integrated care delivery and value-based payments	Work with DPA to explore contractual requirements regarding integrated care delivery and value-based payments as part of upcoming state health employee plan re-procurement process	SIM Office; Policy Workgroup	Practice Transformation; Payment Reform	Use state employee health plan to expand number of Coloradans with access it integrated care supported by value-based payments
Identify areas of anti-trust laws that impeded integrated care at clinical, operational or financial levels	Assess and review anti-trust laws over the course of the model test, to identify issues/barriers that may impact the development of alternative payment models	SIM Office; Policy Workgroup	Practice Transformation	Create legal framework that protects the public while supporting the development of alternative payment models
Financing, Quality Improvement, and Sustainability				

SIM Component/Project Area: *Leveraging Regulatory Authority*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Explore mechanisms for aligning the administration and reimbursement of physical and behavioral health benefit under Medicaid and the Accountable Care Collaborative BHO contracts and carve-out	• Provide comment to Colorado's Accountable Care Collaborative Phase II development in support of combined administration and value-based funding mechanism for physical and behavioral health • Provide comment on HCPF's proposed payment methodology for the Certified Community Behavioral Health Center (CCBHC) planning grant	SIM Office; Policy Workgroup	Payment Reform	Align Medicaid approach to value-based payments and alternative payment models with SIM
Determine which Medicaid waivers will be necessary for implementation of the Model Test	Evaluate mechanisms to maximize hospital provider fee as Medicaid shifts from fee-for-service reimbursement to alternative payment models, and the need for federal approval	SIM Office; Policy Workgroup	Payment Reform	Determine need and apply for any necessary waivers
Clarify current billing regulations, identify barriers to the reimbursement of integrated care, develop solutions.	• Clarify issues regarding regulatory barriers to same day billing. • Eliminate barriers to care resulting from diagnosis-based reimbursement requirements under the Medicaid Mental Health Program • Promote the use of Health Behavior and Assessment CPT codes (96150-96155) by all payers under the current payment environment	SIM Office; Policy Workgroup	Payment Reform	Remove regulatory and administrative barriers to value-based payments, alternative payment models
Identify and evaluate risk-bearing requirements for providers	• Work with the DOI to ensure the proper regulatory protections are in place to guard against over-extended risk, insufficient pooling, and market failure • Explore use of state regulations or guidance that would encourage the adoption of successful risk-bearing arrangements/methodologies	SIM Office; Policy Workgroup	Payment Reform	Ensure marketplace protections while allowing/encouraging alternative payment models involving risk sharing

SIM Component/Project Area: *Leveraging Regulatory Authority*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Expand outcomes-based reimbursement mechanisms to include public health services	• Review commercial and public insurance regulations regarding ability to reimburse for population health services • Work with payers regarding the integration of LPHAs into alternative payment models • Explore use of network adequacy requirements to expand the inclusion of LPHAs in provider networks	SIM Office; Policy Workgroup	Payment Reform	Provide sustainable funding source for LPHAs
Examine potential use/alignment of community needs assessments as a mechanism for addressing issues of system capacity and controlling costs	Work with stakeholder to coordinate/align ongoing community needs assessment activities to identify issues of local and regional system capacity	SIM Office; Policy Workgroup	Practice Transformation	Utilize existing community health needs assessments to identify better, more efficient ways of allocating resources and saving costs
Fraud and abuse	Review federal and state fraud and abuse laws and identify potential barriers to integrated care delivery and payment models	SIM Office; Policy Workgroup	Practice Transformation	Ensure all model components are in compliance with state and federal fraud and abuse statutes and regulations
HIT				
Monitor federal health IT policy, programs, and standards recommendations and disseminate statewide	Work with the Office of eHealth Innovation to monitor federal activity around IT standards, and disseminate any new regulations or standards	SIM Office; Policy Workgroup; HIT Workgroup	HIT	Remain in compliance with and up-to-date on federal regulations, standards, and programs, including recourses available to state
Identify mechanisms for sustainable funding of HIT initiatives	• Pursue federal opportunities for matching funds to support interoperability between state agencies and statewide HIE, and electronic health record adoption and meaningful use • Explore the use of subscription fee for entities that submit or receive data from SIM's central data hub warehouse	SIM Office; Policy Workgroup; HIT Workgroup	HIT	Establish funding mechanisms to ensure HIT sustainability

SIM Component/Project Area: *Leveraging Regulatory Authority*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Identify policy or regulatory mechanisms to incent prayers and providers to participate in data collection and reporting systems	• Use success of SIM models to demonstrate potential return on investment for participating in statewide data collection systems (benefits of EHRs, connecting to HIE) • Explore the use of regulations, such as requiring participating in data collection and reporting as part of the health certification process	SIM Office; Policy Workgroup; HIT Workgroup	HIT	Garner payer and provider support and participation in data collection and reporting systems
Standards for HIT tools	Explore the utility and or effectiveness of instituting requirement that HIT tools used within the state to adhere to federally endorsed standards	SIM Office; Policy Workgroup; HIT Workgroup	HIT	Ensure quality of HIT tools in the state
Evaluate telehealth regulations to identify potential barriers for widespread adoption, and identify policy solutions	• Evaluate issues including, but not limited to: - Reimbursement - Prescribing - Home monitoring	SIM Office; Policy Workgroup; HIT Workgroup	HIT	Utilize policy and regulatory levers to remove barriers and support/promote the adoption of telehealth

Quality Measure Alignment

One of the core objectives behind the selection of the process and outcome measures included in the Colorado SIM minimum dataset was to leverage and consolidate existing measures that have been agreed upon by payers and providers in the state. Because a diversity of constituents will both provide and use data gathered by SIM, measures were also selected for their ability to serve multiple purposes, to limit the reporting burden on frontline provider and maximize impact.

Colorado has a history of voluntary state agency coordination and collaboration around measures, as demonstrated by the Colorado Cross-Agency Collaborative. This Collaborative – between CDHS, CDPHE, and CDHCPF – was formed to break down silos and create a data strategy between state health agencies, and share and align metrics through the life course. In doing so, it allows agencies to better coordinate care by identifying current gaps and to collectively identify where resources should be focused to better tackle health disparities in the state. The MPC also fosters agency alignment around joint priorities, which may reduce the duplication and overlapping of health initiatives. CDPHE, CDHCPF and CDHS have also recently partnered with the Colorado Department of Education to align measures that target social emotional development in early childhood as part of the Colorado Opportunity Project. (For a complete description of the Colorado Opportunity Project, please see the ***Plan for Improving Population Health*** and ***SIM Alignment with State and Federal Initiatives*** sections of the Operational Plan).

The SIM minimum dataset is rooted in these principles of collaboration and cooperation, to align not only with current state activities, but also with federal initiatives currently underway in Colorado. These include, but are not limited to, CPCI, TCPI, and measures used by Medicaid.

Alignment with CPCI Measures

The CQMs that will be included in the SIM dataset are closely aligned with those used by CPCI, with the addition of three behavioral health measures: depression screening NQF 0418 or NQF1401, SUD Screening NQF Composite 2597, and Anxiety Screening GAD-7.

Alignment with TPC Measures

Since the time of the initial SIM application, Colorado has been selected to participate in TCPI. TCPI measures include tobacco usage, congestive heart failure, imaging for low back pain, hospitalizations,

re-hospitalizations, and ER visits. They do not measure flu, SUD screening, maternal depression, developmental screening, anxiety, and safety.

Alignment with Medicaid Measures

Accountable Care Collaborative

RCCOs, the lead organizations in Colorado's ACC program, are held to performance on quality and utilization measures which are tied to payment. Quarterly incentive payments are made when the RCCO meets or exceeds the state's quality target on three KPIs, calculated based on performance in the region:

- Emergency room visits per 1,000 full-time enrollees;
- Percent of children ages 3-9 receiving well-child checks; and
- Percent of women receiving postpartum care after delivery.

The KPIs are paid out quarterly if targets are met for ER visits and well-child checks, and annually if targets are met for postpartum care delivery.

The ACC also has an incentive performance pool that is used to pay RCCOs based on their relative performance for the rate of clients who had a physician visit within 30 days of a hospital discharge.

Accountable Care Collaborative: Medicare-Medicaid Program

The ACC's Medicare-Medicaid Program, started in June 2014, offers payments to RCCOs based on performance of three KPIs:

- Depression screening (NQF 0418 – Preventive Care and Screening – Screening for Clinical Depression and Follow-Up Plan);
- Emergency Room Visits (defined using revenue codes and CPT 4 combinations); and
- Thirty (30) Day All Cause Readmissions (identified admissions include general acute care hospitalizations and acute inpatient psychiatric hospitalizations for psychiatric conditions and substance abuse).

A set of "Shared Savings" quality metrics will also be use as part of the demonstration agreement with CMS. These measures will be calculated by Truven and supplied to CMS for CY 15, 16, and 17.

The following table provides an overview of SIM's current alignment with CPCI, TCPI, and the ACC:MMP.

Measure condition	Citation	Data Source	SIM	CPCI	TCPI	ACC: MMP
Breast Cancer Screening	NQF 0031	Claims	X	X	X	
Colorectal Screening	NQF 0034	Claims	X	X	X	
Depression Screening	NQF 0418 or NQF 1401	Reported by practice	X		X	X
SUD screening	NQF Composite 2597	Reported by practice	X			
Flu	NQF 0041	Reported by practice	X	X		
Asthma	NQF 0036	Reported by practice	X	X	X	
Obesity	NQF 0421 or NQF 0024	Reported by practice	X	X	X	
Depression Screening	NQF 0418	Reported by practice	X	X	X	
Maternal Depression	NQF 1401	Reported by practice	X	X		
Developmental Screening	NQF 1448	Reported by practice	X			
Anxiety	GAD-7	Reported by practice	X			
Hypertension	NQF 0018	Partial claims (diagnosis only) + Reported by practice	X	X	X	
Diabetes: Comprehensive Care	NQF 0059	Partial claims (diagnosis only) + Reported by practice	X	X	X	
Diabetes: Blood pressure management	NQF 0061	Reported by practice	X	X	X	
Safety	NQF 0101	Reported by practice	X	X		

Colorado SIM will work with CDHCPF to align measures that may be included in Phase II of the ACC, and the recently awarded Planning Grant for Certified Community Behavioral Health Centers.

For a description of SIM's alignment of Clinical Quality measures with Population Health measures, please see the ***Existing Capacity and Efforts around Population*** subsection of the ***Plan for Improving Population Health*** section of the Operational Plan.

Component Summary Table

SIM Component/Project Area: *Quality Measure Alignment*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Coordinate and align measures used in state and federal initiatives	• Review new and existing state and federal initiatives to identify areas of coordination and alignment with SIM dataset • Support/promote efforts at the federal level to coordinate and align measurement collection and reporting requirements across initiatives	SIM Office	Practice Transformation; Payment Reform; Population Health; HIT	Coordination and alignment of measures across state and federal initiatives, resulting in reduced burden on practices and providers
Evaluate the need to establish a formal mechanism, process, or entity to review and coordinate measure alignment within the state	• Determine the benefits vs. costs of establishing a statewide coordination and/or alignment process • Explore potential mechanisms for instituting at the state level	SIM Office	Practice Transformation; Payment Reform; Population Health; HIT	Increased awareness, coordination among multiple state entities and organizations; increased leveraging of available resources

SIM Alignment with State and Federal Initiatives

Colorado SIM leverages a strong foundation of federal, state, and private sector investments in primary care transformation and integrated care. Colorado SIM will build upon the foundation of prior initiatives in order to consolidate and further align statewide efforts to create and sustain long-term, comprehensive innovation.

The Colorado SIM Office will work to ensure SIM initiatives are aligned with other health care projects, programs, and initiatives in the state in several key areas. First, SIM will work to maintain philosophical alignment among various initiatives around the key end goals of health care transformation in the state. In the State of Health report, Governor Hickenlooper articulated the following:

"Our vision is a future where health and well-being are as much a part of Colorado's way of life as our mountains, clear skies, and pristine environment. Instead of only focusing on sickness, we will support Coloradans in their efforts to stay healthy or become healthier. Our health delivery networks will be comprehensive, person-centered, high-quality, and affordable. They will integrate physical, behavioral, oral, and environmental health with community-based long-term services and supports, and support individual health with HIT."

Colorado SIM represents an opportunity to help make this vision a reality, but the true achievement of the Triple Aim is beyond the scope of any one initiative. SIM will take a leadership role in promoting information sharing and coordination between state, local, and non-governmental organizations to increase opportunities for potential alignment on future health initiatives. Specific strategies will include: 1) pooling resources to advance similar initiatives, such as the joint funding opportunity issued by SIM and the Denver Foundation for regional behavioral health collaboratives; 2) coordinating and aligning regulatory approaches to ensure changes to the existing oversight framework are complementary, rather the duplicative, contradictory, and/or fragmented; 3) aligning program requirements, such as outcome measures whenever possible, to minimize reporting burden and "reform fatigue."

Colorado SIM will also ensure that federal funding will not be used for duplicative activities, or to supplant current federal or state funding. Documents used in the procurement process – including RFPs and RFAs – will list and include a description of existing federal initiatives that may overlap with the current funding opportunity, and clearly state that funds cannot be used for duplicate activities. The SIM Office will also educate vendors, contractors, providers, and other stakeholders on the requirements

and restrictions of federal initiatives related to SIM activities, as well as the requirements to keep funding streams separate. Finally, SIM will review and actively monitor submitted budget proposals and adjustments, to ensure funds are being used appropriately.

Coordination between SIM and Other Federal Initiatives

Colorado SIM builds on, and aligns with, numerous CMMI, HHS, and federal initiatives that support high-performing primary care and integrated behavioral health. Examples include, but are not limited to:

1115(a) Medicaid Demonstrations

Colorado's decision to expand Medicaid coverage to low-income Coloradans earning up to 133 percent of the FPL under the ACA, signed into law in by Governor Hickenlooper in 2013, replaced the state's previous 1115 waiver to cover some Colorado Adults Without Dependent Children.

The state currently has only one 1115 waiver in place – the Colorado Adult Prenatal Coverage and Premium Assistance CHP+ waiver – which provides title XXI coverage for uninsured pregnant women with income above 141 percent through 195 percent of FPL. Colorado recently received approval from CMS to extend this wavier through July 31, 2020.[49]

Medicaid-led Transformation Efforts

ACC

Colorado SIM is building off the health system transformation efforts led by the ACC, Colorado Medicaid's main delivery system, and has worked with CDHCPF to program philosophies and objectives. To date, the ACC has aligned with and is supporting SIM goals by:

- Moving to one administrative entity for physical and behavioral health in each of our seven regions in the second iteration of the ACC (new contracts will go into effect in July 2017). This change will promote integration and enhance care coordination to include physical and behavioral health needs;
- Recognizing Primary Care Medical Providers (PCMPs) who meet five of nine enhanced provider factors, demonstrating that they are offering services beyond a traditional fee-for-

[49] CMS Approval Letter, available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/co/co-adult-prenatal-coverage-ca.pdf

service model of primary care. Two of the potential factors feature behavioral health integration: 1) on-site access to behavioral health care providers, and 2) using a Medicaid-approved tool to conduct developmental screenings for children, or behavioral health screening for adults and adolescents and having documented procedures for addressing positive screens. As of May 2015, about half of all PCMPs in the ACC program (265 practices) had been validated as meeting at least five of the possible nine standards. Together, these practices had about 500,000 ACC clients attributed to them. Of the 270 practices that met at least five standards, 54 percent offered on-site behavioral health care, and 71 percent had regular procedures for developmental and behavioral screenings;

- **The ACC: Rocky Mountain Health Plans PRIME program** has included additional payments to PCMPs in advanced practices for the employment of behavioral health providers on comprehensive care teams. The Department pays its contractor, Rocky Mountain Health Plans (RMHP), a full risk capitation. In turn, RMHP pays participating providers global, monthly payments for primary care services. Three practice sites also receive global monthly payments to support integrated behavioral health providers within their practice. Clients using these advanced PCMPs have direct access to behavioral health services in the course of routine visits. In the next year, seven more practices will add integrated behavioral health services using this model. Further, the program's innovative payment model has allowed CMHCs to contract, alongside the PCMPs, with RMHP to implement an aligned gainsharing arrangement. In the event that savings are achieved across the entire global budget for services and minimum quality targets are achieved, the CMHCs are eligible for a 30 percent share of total financial gains. CMHC leaders work directly with RMHP at the executive level to manage the planning, data sharing, and operations necessary to support this model. CMHC leaders also sit on the executive committee that provides region-wide oversight for the program, and work to ensure accountability and transparency within the initiative. The medical loss ratio for this program is tied to four quality measures—three HEDIS measures and the Patient Activation Measure. The quality measures were chosen to align with CQMs that PCMPs are working on in other programs, such as the CPCI;
- Investing in telehealth technology to support behavioral health integration. The ACC Chronic Pain Disease Management program promotes integration and building relationships between local providers by supporting the participation of teams with both behavioral health and physical health providers. The program encourages behavioral health providers

who are currently not integrated with a primary care provider to collaborate and co-present cases together with a primary care provider;

- Establishing Opportunity Liaison FTE positions RCCOs through the Colorado Opportunity Project. These professionals will focus on interventions with positive, measurable outcomes in the Family Formation life stage of the Opportunity Project. One of the key metrics in this life stage is the rate of maternal depression. The specific type support provided by the Liaisons will depend on community needs and current infrastructure. The Liaisons will also work to align their efforts with other initiatives already occurring in these communities;
- Using the RCCO incentive pool to provide financial support to practices participation in SIM Cohort 1;
- Measuring the rates of receipt of USPSTF A and B rated preventive services among the Medicaid and ACC populations, including depression screening, and working to increase the receipt of these services; and
- Allowing integrated CMHCs to apply to be PCMPs within the ACC. This designation allows the Centers to receive client attributions and to receive per member per month payments for their attributed clients. As of November 2015, two CMHCs have enrolled in the ACC as a PCMP.

In addition, Medicaid's BHOs are working to align efforts with physical health providers ahead of the reprocurement of the ACC program. For example, they are working to evaluate the behavioral health needs of the clients of PCMPs in several regions, engage in strategic planning processes with PCMPs, promote integrated services in school-based settings, and encourage co-location of mental health and substance abuse disorder services with PCMPs.

Starting on July 1, 2014, CDHCPF took the first steps to recognize and reimburse Primary Care Medical Providers (PCMPs) that offer services beyond the traditional FFS primary care model of care by offering additional PMPM payments to PCMPs who meet five out of nine enhanced primary medical home factors. The nine factors are based on the medical home standards from National Committee on Quality Assurance, recommendations from the RCCOs and other stakeholders, Colorado Senate Bill 07-130, which defined the criteria for medical homes for children, and other key CDHCPF initiatives designed to incentivize quality improvement. They include:

1. Extended Hours - has regularly scheduled appointments (at least once per month) on a weekend and/or a weekday outside of typical work day hours;

2. Timely Clinical Advice - provides timely clinical advice by telephone or secure electronic message both during and after office hours. Patients and families are clearly informed about these procedures;
3. Data Use and Population Health - uses available data to identify special patient populations that may require extra services and support for medical and/or social reasons. The practice has procedures to proactively address the identified health needs;
4. Behavioral Health Integration - provides on-site access to behavioral health care providers;
5. Behavioral Health Screening - collects and regularly updates a behavioral health screening (including substance use) for adults and adolescents, and/or developmental screening for children (newborn to five years of age) using a Medicaid-approved tool. In addition, the practice has documented procedures to address positive screens and has established relationships with providers to accept referred patients or utilizes the standard referral and release form created by the BHOs;
6. Patient Registry – generates a list of patients actively receiving care coordination;
7. Specialty Care Follow-Up - tracks the status of referrals to specialty care providers and provides the clinical reason for the referral along with pertinent clinical information;
8. Consistent Medicaid Provider - accepts new Medicaid clients for the majority of the year; and
9. Patient-Centered Care Plans - collaborates with the patient, family, or caregiver to develop and update an individual care plan.

The nine enhanced standards align with to a substantial degree with the CPCI milestones, and the SIM Practice Transformation Milestones adopted by SIM. CDHCPF's use of a financial incentive offers providers in the state with alternative source of funds to efforts to strengthen primary care delivery, which will bolster and improve SIM's practice transformation efforts.

No Wrong Door Initiative (HHS Administration for Community Living)

In October 2015, Colorado Medicaid received a grant from the Administration for Community Living at the U.S. Department of Health and Human Service to implement a "No Wrong Door" initiative. Project funding will be used to create pilot programs that provide comprehensive access points for Coloradans seeking long-term services and supports regardless of age, disability, or payer sources, and to improve information about service options of individuals seeking services and their caregivers.

The No Wrong Door initiative is a joint project between CDHCPF, CDHS, State Unit on Aging (SUA), OBH, and the Division of Vocational Rehabilitation (DVR). The implementation funding comes on the heels of

a planning grant, which was developed over the last year through extensive collaboration with stakeholders statewide, including caregivers, clients, provider, private payers, single entry points, community-centered board, area agencies on aging, and RCCOs.

SIM's goal of providing 80 percent of Coloradans with access to integrated primary care and behavioral health services includes all state residents, including those receiving Long Term Services and Support (LTSS). This population has historically experienced greater difficulty receiving access to needed care and services; the No Wrong Door initiative represents an important public-private collaboration to address some of these issues. Colorado SIM will be able to build off of, and potentially expand, the successes achieved by the program.

Testing Experience and Functional Tools (TEFT) Demonstration Grant

In March 2014, Colorado received a TEFT planning grant from CMS to test quality measurement tools and demonstrate e-health in Medicaid community-based long term services and supports (CB-LTSS). The program is designed to field test an experience of care survey and a set of functional assessment items, demonstrate personal health records, and create a standard electronic LTSS records. Grantees will have an opportunity to extend the grant period to a total of four years.

Colorado is participating the following TEFT components:

- Experience of Care (EoC) Survey – The EoC survey elicits feedback on beneficiaries' experience with the services they receive in Medicaid CB-LTSS programs. It was designed as a cross-disability survey, i.e., it is population agnostic. As a contractor to CMS, Truven Health Analytics is currently conducting a field test of the survey in all nine grantee states with a range of CB-LTSS beneficiaries, including frail elderly, physically disabled, intellectually disabled and developmentally disabled, those with acquired brain injury and person with severe mental illness. In the out years of the demonstration, grantees will administer the finalized survey to their CB-LTSS beneficiaries and use the results to assess and improve quality in their programs;
- Continuity Assessment Record and Evaluation (CARE) – Under prior initiatives, CMS invested in the development of the CARE for use in post-acute care settings. Under TEFT, Research Triangle Institute modified some CARE items for assessing CB-LTSS beneficiaries. TEFT grantees will provide a sample of beneficiaries across disabilities upon which the adapted

CARE items will be field tested in 2015. Following the field test, the CB-LTSS items will be finalized and grantees will then demonstrate their use in their CB-LTSS programs;

- Personal Health Record (PHR) – Grantees will demonstrate use of PHR systems with beneficiaries of CB-LTSS. The PHR is intended to provide CB-LTSS grantees with a range of personal LTSS and health information to facilitate decision making about care. The PHR can encourage a more active role for beneficiary/caregivers in managing care and result in better outcomes through more efficient management of services; and
- Electronic Long Term Services and Supports Standard (e-LTSS) – Grantees will pilot test an eLTSS standard in conjunction with the ONC's Standards and Interoperability (S&I) Framework.

The TEFT Demonstration Program marks the first time that CMS is promoting the use of HIT (HIT) in CB-LTSS systems. TEFT will provide national measures and valuable feedback on how HIT can be implemented in this component of the Medicaid system. Lessons learned through this program may inform efforts to improve and increase the use of HIT with other patient populations, both inside and outside of the Medicaid system.

Colorado Choice Transitions (CCT)

Colorado Choice Transitions (CCT), part of the federal Money Follows the Person (MFP) Rebalancing Demonstration is a five year grant program. The primary goal is facilitating the transition of Medicaid clients from nursing or other long-term care (LTC) facilities to the community using home and community based (HCBS) services and supports. Services are intended to promote independence, improve the transition process, and support individuals in the community. Participants of the CCT program will have access to qualified waiver services as well as demonstration services. They will be enrolled in the program for up to 365 days after which time they will enroll into one of five HCBS waivers so long as they remain Medicaid eligible.

Comprehensive Primary Care Initiative

To achieve its ambitious vision and goals, SIM will be leveraging the work of payers and providers currently participating in CPCI. This includes the MPC, established by payers participating in CPCI, as discussed in the ***Payment and Service Delivery Models*** section of the Operational Plan.

SIM will align and build off the work of the MPC and CPCI in several key areas:

1) Data aggregation

Colorado's SIM HIT plan will build upon the Stratus tool developed by payers participating in CPCI, the first system of this kind, to be used on this scale – by connecting the CPCI administrative data hub to a clinical data to create a centralized data repository that will aggregate clinical and claims information, and provide consolidated reporting for providers to public and commercial payers and give population and practice benchmarking information to providers and payers. A centralized integrated platform that will amalgamate clinical quality and cost data and will provide clear and meaningful performance measures, communicate performance to stakeholders, and provide actionable detail.

The hub will create a platform for shared care planning resources and a non-condition specific repository for state population health evaluation. It will leverage the existing Master Patient Index (MPI), provider directories and other tools. Building on clinical information, the phased approach will link to administrative claims information via the APCD and other sources as needed, providing a central aggregated clinical and cost data hub.

2) Value-based payments

A key focus of the MPC has been the development of a framework that will allow participating public and private payers to expand value-based payments within their own networks to CPCI participating practices that are engaged in transformation activities and that meet specific milestones. This allows practices to advance their knowledge and demonstrated ability to support this model of care at a level that makes the most sense to them. The MPC continues to be engaged in aligning payment measurements and data sharing processes in a way that will help practices achieve their goals.

Building upon the MPC's foundational work under CPCI, Colorado SIM will leverage private payers' commitments to migrate toward prospective, non-volume payments, as providers become capable of adopting these new payment models. We anticipate that practices selected to participate in SIM will persist in advancing through components of the payment models established under CPCI, which will help improve likelihood of receiving enhance funding from public and private payers. We also expect that the participation in CPCI, SIM, or both, will increase practices' capacity to serve larger groups of patients more effectively and efficiently, contributing to sustainability. SIM has utilized the basic CPCI measure set as the foundation for its own clinical and quality measures.

3) Practice Transformation/Milestones

Cohorts of SIM-participating practices will include CPCI practices as well as non-CPCI practices. In order to best align practices transformation efforts, the SIM Office adopted ten SIM Practice Transformation milestones that were designed specifically to align with the CPCI Milestones (see the ***Health Care Delivery Transformation*** section of the Operational Plan). Congruence between the key activities that practices are expected to undertake assures alignment between the two initiatives.

Dual integration

In June 2014, CDHCPF received a $13.6 million grant from CMS to implement the State Demonstration to Integrate Care for Medicare-Medicaid Enrollees (Demonstration), which is designed to integrate and coordinate physical, behavioral, and social health needs for Medicare-Medicaid members. Colorado Medicaid members who are eligible for both Medicare and Medicaid comprise approximately seven percent of the Department's Medicaid enrollment, but account for 29 percent of the state's costs.[50] More than 50 percent of Medicare-Medicaid beneficiaries are older than 65, and more than 60 percent of beneficiaries have multiple, chronic health conditions.[51]

CDHCPF built on the ACC's infrastructure, resources and provider networks to implement the program, and in September 2014 began enrolling approximately 30,000 full benefit Medicare-Medicaid enrollees into the ACC program. Early results have highlighted the need for the ACC to formally expand its network and coordinate with agencies such as Single Entry Points (SEPs) and Community Centered Boards (CCBs). As the program continues to evolve, it will provide CDHCPF and other state agencies and organizations with valuable feedback regarding the best ways to achieve the goal of person- and family-centered care, and placing clients/patients at the center of their care planning and delivery.

Medicare Advanced Primary Care

Colorado does not participate in the CMS Multi-Payer Advanced Primary Care Practice initiative.

[50] HCPF press release
[51] ibid

Medicare Shared Savings Programs, including Pioneer ACOs

Shared Savings Program

The following ACOs are currently participating in Medicare's Shared Savings Program and include Colorado in their service area:

- Central US ACO, LLC;
- Clinical Partners of Colorado Springs, LLC;
- Colorado Accountable Care, LLC; and
- Physician Health Partners, LLC.

Practices within these organizations are eligible and encouraged to apply for participation in one of the SIM cohorts.

Pioneer ACO Model

No ACOs in Colorado participated in CMMI's Pioneer ACO Model in calendar year 2015.

Health Care Innovation Awards

The following seven projects have received Health Care Innovation Award funding and include Colorado in their reach:

Denver Health and Hospital Authority

Project Title: "Integrated model of individualized ambulatory care for low income children and adults"
Description: The goal of the project is for Denver Health to transform its primary care delivery system to provide individualized care to more effectively meet its patients' medical, behavioral, and social needs.

Institute for Clinical Systems Improvement

Project Title: "Care management of mental and physical co-morbidities: A Triple Aim bulls-eye"
Description: Award to improve care delivery and outcomes for high-risk adult patients with Medicare or Medicaid coverage who have depression plus diabetes or cardiovascular disease.

Rutgers, The State University of New Jersey (The Center for State Health Policy)

Project Title: "Sustainable high-utilization team model"
Description: Award to expand and test team-based care management strategy for high-cost, high-need,

low-income populations served by safety-net provider organizations in Allentown, PA, Aurora, CO, Kansas City, MO, and San Diego, CA.

Southeast Mental Health Services

Project Title: “TIPPING POINT: Total Integration, Patient Navigation and Provider Training Project for Prowers County, Colorado”
Description: Southeast Mental Health Services received an award to coordinate comprehensive, community-based care for high-risk, high-cost, and chronically ill residents of rural Prowers County, Colorado.

Trustees of Dartmouth College

Project Title: “Engaging patients through shared decision making: using patient and family activators to meet the triple aim”
Description: The High Value Healthcare Collaborative (HVHC) received an award led by The Trustees of Dartmouth College to implement patient engagement and shared decision making processes and tools across its 15 member organizations for patients considering hip, knee, or spine surgery and complex patients with diabetes or congestive heart failure. The program will hire and train 48 health coaches across the 15 member organizations to engage patients and their families in their health care and health decisions.

University of North Texas Health Science Center

Project Title: “Brookdale Senior Living (BSL) Transitions of Care Program”
Summary: The University of North Texas Health Science Center (UNTHSC), in partnership with BSL, is developing and testing the Brookdale Senior Living Transitions of Care Program, which is based on an evidenced-based assessment tool called Interventions to Reduce Acute Care Transfers (INTERACT) for residents living in independent living, assisted living, and skilled nursing facilities in Florida, Colorado, Kansas, and Texas

Upper San Juan Health Service District

Project Title: “Southwest Colorado cardiac and stroke care”
Description: The Upper San Juan Health Service District is improving care for cardiovascular disease and risk through a multifaceted approach in order to reduce costs and to improve the quality of care in rural and remote areas of southwestern Colorado.

All projects support Colorado SIM's vision and goal. In particular, Southeast Mental Health Services will be awarded SIM funds through the Bi-Directional Integration Demonstration and Practice-Based Research Pilot Program (***see the Health Care Delivery Transformation Plan section*** for more details on this program, which will complement the TIPPING POINT project funded through Healthcare Investment Analysis [HCIA]). Representatives from all HCIA-funded projects in Colorado will be invited to the biannual SIM conference.

Bundled Payment Initiatives

Retrospective bundled payment arrangements are being tested at 16 sites in Colorado – including hospitals, orthopedic practices, skilled nursing facilities, and home health care agencies – as part of CMMI's Bundled Payments for Care Improvement Initiative (BPCI). Colorado's employer purchasing coalition, the Colorado Business Group on Health, is sponsoring PROMETHEUS bundled payment pilots for chronic conditions with self-insured employers in Alamosa, Colorado Springs, and Boulder. As Colorado's Regional Health Improvement Collaborative, CIVHC is developing bundled payments for acute care episodes with physician groups and hospitals in metro Denver. One of the state's major commercial insurers is also working with hospitals to develop bundled payments for certain acute episodes.

The Colorado Public Employees Retirement Association recently began offering fixed-cost hip or knee replacement procedures to pre-Medicare retirees and their dependents enrolled in a plan called PERACare Select, administered by Anthem Blue Cross Blue Shield. PERA contracted with a select group of doctors and facilities in the Denver metro area to establish a fixed price for a "suite" of services, from intake to discharge, that includes the surgery, hardware, anesthesia, and pain block and management. Plan enrollees who chose one of PERACare Select's designated providers may have their co-payments or other cost-sharing requirements waived, resulting in out-of-pocket savings of up to $13,000. PERA officials are using the hip and knee replacement program as a pilot to evaluate the viability and efficacy of using fixed costs in future negotiations for health care services.

In addition, CMS selected four Colorado Metropolitan Statistical Areas (MSAs) to participate in the proposed Comprehensive Care for Joint Replacement Model. This initiative intends to test bundled payment and quality measurement for an episode of care associated with hip and knee replacements to encourage hospitals, physicians, and post-acute care providers to work together to improve the quality and coordination of care from the initial hospitalization through recovery.

The Colorado SIM approach to payment reform gives payers and providers the flexibility to work together to develop alternative payment models that are tailored to meet their respective needs. SIM anticipates that bundled payments will be included as a component of alternative payment models, and will align with and incorporate best practices from past and ongoing bundled payment initiatives in the state. SIM's bi-directional pilot project, administered through CBHC will explore the use of performance-based incentive payments, braided funding, and bundled, risk-adjusted payment mechanisms within CMHCs. (Please see the ***Health Care Delivery Transformation Plan*** section of the Operational Plan for additional details on this program.) Medicaid may also include bundled payments as part of its reimbursement structure the Phase II of the ACC. Bundled payments, particularly as developed and utilized by health plans, hospitals and specialty physicians around acute care episodes, may serve as an important interim prospective payment strategy on the path toward global payments.

Meaningful Use and Health Information Technology for Economic and Clinical Health (HITECH)

A discussion of SIM's alignment with federal Meaningful Use and HITECH initiatives can be found in the ***HIT*** section of the Operational Plan.

Initiatives from related agencies such as CDC, ONC, SAMHSA, HRSA, and AHRQ

Substance Abuse and Mental Health Services Administration (SAMHSA)

Colorado was one of 24 states to receive a Planning Grant for the Certified Community Behavioral Health Clinics program from the SAMHSA, in conjunction with CMS and the Assistant Secretary of Planning and Evaluation (ASPE). CDHCPF will use the funds to develop a process for certifying community behavioral health clinics, solicit input from stakeholders, establish prospective payment systems for demonstration reimbursable services, and prepare an application to participate in the demonstration program.

CDHCPF is currently engaging with state and community partners to move forward on all aspects of the grant, including developing a prospective payment system, establishing criteria for clinic certification, identifying mechanisms for stakeholder outreach and engagement, and evaluating current workforce capacity and needs. The SIM Office is participating in these planning activities, to identify and assist with areas of potential program overlap. The timing of the CCBHC grant, which coincides with CDHCPF's consideration of new care delivery and payment strategies as part of the ACC restructuring and RCCO re-bid process, allows for a dovetailing of the two programs. SIM will continue to be a part of the larger discussions about Medicaid's short- and long-term strategies for integrating physical and behavioral

health and moving to alternative payment models, and working to ensure they align with SIM's vision and goals around statewide, multi-payer strategies.

Agency for Healthcare Research and Quality (AHRQ):

Colorado SIM will align its transformation efforts with existing opportunities and resources that AHRQ presents, particularly with EvidenceNow Southwest, an initiative aimed at "transforming health care delivery by building critical infrastructure to help smaller primary care practices apply the latest medical research and tools to improve heart health." Up to 260 primary care practices across Colorado and New Mexico will participate in the initiative, designed to improve outcomes associated with the ABCS of cardiovascular disease:

- Aspirin use by high-risk individuals,
- Blood pressure control,
- Cholesterol management, and
- Smoking cessation.

EvidenceNow Southwest is based at the University of Colorado, Department of Family Medicine, which has been contracted to lead practice transformation activities for cohorts of SIM-participating primary care practices. Leadership at the Department of Family Medicine has committed to including relevant EvidenceNow Southwest resources in the SIM Practice Transformation toolboxes that are in development and to aligning transformation activities across the two initiatives. (For additional information on EvidenceNow, please see the ***Health Care Delivery Transformation Plan*** section of the Operational Plan.)

Furthermore, the Department of Family Medicine team will play a crucial role in guiding the deployment of SIM Regional Health Connectors, described in the ***Regional Health Connector*** subsection of the ***Plan for Improving Population Health*** section of the Operational Plan. Because AHRQ has already funded six Regional Health Connectors to focus on EvidenceNow South West practices, the Department of Family medicine has committed to aligning guidance, training, and resources provided to SIM-funded Regional Health Connectors with this existing workforce.[52]

[52] ENSW |FOR PRACTICES | University of Colorado Denver. (n.d.). Retrieved November 6, 2015. http://www.evidencenowsw.org/tablet/for-practices.html

Colorado SIM has also been in communication with HRSA about a Health Care Transition Model, a program that addresses the issues associated with transition youth. SIM recognizes the importance of addressing this population, and will consider how HRSA's model may be incorporated into SIM in the future.

CDC

The ***Plan for Improving Population Health*** section of the Operational Plan outlines how Colorado's SIM approach aligns with CDC activities, including Essentials for Childhood and CDC Winnable Battles.

Transforming Clinical Practice Initiative

Colorado's Collaborative for Practice Transformation, a partnership of public and private entities under the leadership of the Governor's Office, was recently selected to participate in CMS's TCPI. Colorado will receive up to $11 million over the next four years to provide technical assistance to help equip clinicians throughout Colorado with tools, information, and network support needed to improve quality of care, increase patients' access to information, and spend health care dollars more wisely.

The grant represents another opportunity to provide practice support to both specialists and primary care clinicians in the state, and assist them in working together more effectively and preparing them for new practice and payment models. TCPI complements other statewide initiatives that address how health care is delivered and paid for, and it should lead to better patient experiences at a lower cost. A substantial part of the work will involve supporting practices as they change the way they operate so they may provide integrated care, which aligns and complements the work of SIM. Together, these opportunities will be important steps toward building a comprehensive and person-centered statewide system that addresses a broad range of health needs.

The TCPI application narrative was developed to align with and not duplicate SIM efforts. SIM is focused on primary care and behavioral health providers while TCPI is focused on pediatricians and specialists (although primary care providers are eligible). The focus of TCPI is the medical neighborhood—this is a great opportunity to support the health care community by coordinating and aligning these funding opportunities. Members of the Colorado SIM team, in partnership with the SIM Director, the TCPI program manager, and the TCPI faculty and staff at the University of Colorado Department of Family Medicine, are working on a proposal that will clearly outline the relationship between SIM and TCPI for health systems and providers as well as identify opportunities to participate in both if applicable. For example, with the timeline of Colorado SIM, some practices could potentially be prepared through TCPI

to be ready and eligible for the later cohorts enrolling in SIM, which requires a baseline level of competencies and services similar to those targeted in TCPI. Our proposal will include a matrix of possible options with inclusion criteria and a protocol to seek approval from CMS. We anticipate submitting this proposal to the SIM steering committee in January or February and will also continue to communicate with our project officers as we develop the proposal.

Coordination with Non-Federally Funded Initiatives

Regional Health Improvement Collaboratives

Numerous private organizations in Colorado are support collaboration efforts to improve health at the community and regional level. Examples of such activities are outlined below.

Denver Foundation

The Denver Foundation offers community grants to address basic human needs, including basic physical and behavioral medical care. The organization prioritizes innovative, collaborative projects and proposals that work across systems to build on community assets, improve access to services, offer longer-term access to necessary support, and ensure the safety net better meets our community's needs. The Colorado Health Access Fund (Fund), created within the Denver Foundation as a Field of Interest fund in 2014, supports programs and activities that generally increase access to health care and strive to improve health outcomes for populations in Colorado with high health care needs. Between 2015 and 2022, the Fund is committed to allocating resources among rural, urban, and suburban areas with a focus on four categories of projects: 1) Education of those with high health needs, as well as their families and caregivers; 2) Transitions in care; 3) Innovation of care delivery; and 4) Improved access to care, particularly in rural communities. The ***Plan for Improving Population Health*** explains how CDPHE partnered with the Denver Foundation on an RFA to fund Regional Health Collaboratives.

Colorado Trust

The Colorado Trust offers grants across a variety of areas, including community partnerships, health policy and advocacy, health data and information, health and well-being, and health equity investments. For additional information on the Colorado Trust, including its Community Partnerships initiative***,*** see the ***Existing Capacity and Efforts Aimed at Population Health*** subsection of the ***Plan for Improving Population Health.***

Colorado Project LAUNCH

Project LAUNCH seeks to improve coordination across child-serving systems, build infrastructure, and increase access to high-quality prevention and wellness promotion services for children and their families. For additional information on Project LAUNCH see the ***Existing Capacity and Efforts Aimed at Population Health*** sub-section of the ***Plan for Improving Population Health.***

Community benefit programs sponsored by non-profit hospitals/businesses

Colorado has numerous institutions and organizations engaged in community benefit programs, including non-profit hospitals, payers, businesses, state agencies, and philanthropic organizations. Although Colorado law does not require non-profit hospitals to report community benefits to state agencies, these entities are bound by ACA and Internal Revenue Service (IRS) requirements to report on the community benefits they provide. Consumer organizations have expressed some concerns about the accessibility of this information, however, which is reported in complicated and often lengthy forms and reports.

In an effort to promote transparency and improve the visibility of unique community health programs throughout the state, the CHA conducts an annual statewide community benefits survey of its member hospitals and health systems. The CHA also provides toolkits and other communication materials to members to help promote their community benefit activities.

Recently, the University of Colorado's Anschutz Medical Campus received a $250,000 grant from the Health Impact Project, a collaboration of the Robert Wood Johnson Foundation and The Pew Charitable Trusts, to implement an initiative that will support the use of community Health Impact Assessments (HIAs) as part of hospital community benefit activities. The program will build a sustainable infrastructure that all hospitals can use to lead community HIAs, as a practical tool for enhancing decision-making related to health. Examples of current grant activities include:

- **Positive Youth Development in Aurora Public Schools** - The Pediatric Injury Prevention Education and Research Program at the Colorado School of Public Health and Children's Hospital Colorado will conduct an HIA to inform the development of policies to prevent youth and gang violence in the Aurora Public School District. The focus of the HIA will be disciplinary policy and how the district can best collaborate with the police department in pursuit of shared goals. The HIA will also consider other factors that may influence youth and gang violence, such as how

safer spaces may increase opportunities for improved educational attainment and mental health, and reduced violence.

- **Marijuana Policies Related to Child Abuse and Neglect in the State of Colorado -** The Pediatric Injury Prevention Education and Research Program at the Colorado School of Public Health, in collaboration with Children's Hospital Colorado and the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, will conduct an HIA to inform the CDHS' consideration of new policies surrounding how marijuana use should be handled in child abuse and welfare decision making. The recent legalization of recreational marijuana in Colorado has raised numerous questions about the implications for public health. Particular attention has been paid to the anticipated impact on children and to policies that can be put in place to help mitigate them. Policies to deal with marijuana use and child abuse and neglect reporting are of special interest. This HIA will generate recommendations to the state regarding which policies and procedures should be adopted to maximize child health.
- **Federal Boulevard Framework Plan HIA** – This health impact assessment will inform the proposed Federal Boulevard framework plan. While the goal of the framework plan is to provide guidance for future planning, transportation, and economic development investments along the corridor, the HIA will assess the existing conditions and proposed strategies related to health in the area of two light rail (public transportation) stations. TriCounty Health Department – the health department for Adams, Arapahoe, and Douglas counties – will work with local government planning and community partners to inform the planning decision through the HIA and provide recommendations for better health outcomes. This HIA is supported through funding from Kaiser Permanente Colorado.
- **City of Sheridan Comprehensive Plan Update** - The Tri-County Health Department will conduct an HIA of Sheridan's Comprehensive Plan update, which is intended to help frame policies that maximize positive health effects and prioritize implementation strategies. The existing Comprehensive Plan, adopted in 2004, focuses on programmatic municipal changes and guidance for specific properties in the community. One objective for the new plan is to include sections on transportation, connectivity, economic opportunities, neighborhood development, and the environment. The HIA will focus on the potential impact on health of roadway improvements, exposure to contaminants from former landfills and brownfields, and opportunities for physical activity.

Local public health department activities and local health education activities

Colorado SIM is committed to aligning with the activities undertaken by LPHAs throughout the state. The ***Plan for Improving Population Health*** section of the Operational Plan provides information on LPHA priorities, locally-identified strategies to address those priorities, and SIM-funded avenues of support.

Community needs assessment completed by not for profit hospitals and health systems

Examples of community needs assessment activities occurring in Colorado include:

Colorado Health Assessment and Planning System (CHAPS)

Colorado's Public Health Act of 2008 (CRS 25-1-501 et. seq.) requires state and local health departments to regularly assess population health and system-wide capacity issues, and develop five-year public health improvement plans that engage communities in health improvement, increase the availability and quality of public health services, and ultimately improve health outcomes. CHAPS provides a standard mechanism for assisting public health agencies with assessment and planning activities in the following required areas: stakeholder engagement, community health assessment, capacity assessment, and the identification of goals, strategies, and priorities. Local public health plans are submitted to the local board of heath for review, and summaries are prepared by the Office of Planning, Partnerships, and Improvement at CDPHE, and reported to the Colorado Board of Health to inform the development of a Comprehensive Statewide Public Health Improvement Plan.

Maternal and Child Needs Assessment

CDPHE's MCH Program conducts a statewide needs assessment of the health and well-being of Colorado's women, children, youth, and their families, including children and youth with special health care needs. For additional information on the MCH needs assessment see the ***Leveraging Population Health Assessment*** sub-section of the ***Plan for Improving Population Health.***

Community Assessment Survey for Older Adults (CASOA)

In 2011, the CDHS, in conjunction with local Area Agencies on Aging and the National Research Center, conducted the Community Assessment Survey for Older Adults to identify the needs of older adults in the community and assess the community's strengths in meeting these needs and supporting successful aging.

Hospital Community Health Needs Assessment

The Patient Protection and ACA (Section 9007) established requirements for freestanding, non-profit hospitals to conduct a community health needs assessment (CHNA) at least once every three years in order to maintain their tax-exempt, or “charitable” status, under section 501(c)(3) of Federal Internal Revenue Code. Such facilities must file a health needs assessment report and a corresponding implementation report, detailing progress towards meeting identified needs, every three years.

SIM will foster communication and collaboration among the private and public entities engaged in health needs assessment activities. SIM’s Population Health Transformation Collaboratives and Regional Health Connectors can serve as valuable resources for entities conducting community assessments and help ensure such implementation activities serve to reinforce the development of coordinated community care systems at the local and regional level. Reciprocally, Collaboratives and Regional Health Connectors will be able to build upon and leverage the health improvement activities being conducted by public and private entities within the state.

Other key local initiatives sponsored by city, county or regional public health commissions/agencies, foundations, large employers, academic institutions, community organizations, etc.

As part of its stakeholder engagement strategy, the Colorado SIM Office will conduct annual outreach tours throughout the state. These Outreach Tours will be used as a vehicle for gathering information regarding local initiatives that align with SIM. During Colorado SIM’s first Outreach Tour, community members were asked to provide information on locally-based programs; the SIM Office is currently working to create an inventory of recommended initiatives and will reach out to their leaders in early 2016 in order to discuss next steps for alignment and coordination. For additional information on SIM Outreach Tours see the ***Stakeholder Engagement*** section of the Operational Plan.

BC3 - Better Care, Better Costs, Better Colorado

BC3 is a collective effort to improve health care in Colorado by bringing a diverse group of stakeholders together in a new way to reach shared goals by aligning activities, engaging communities and supporting and building on existing initiatives. The initiative was started in 2014 by the Colorado Health Foundation and is supported through a ten-year funding commitment. Participating organizations and individuals commit to aligning efforts and supporting each other through regular meetings. Participants also commit to measuring effectiveness of both the collective effort and its activities, as well as partnering with the most influential entities and organizations in Colorado.

To date, a Steering Committee – consisting of public and private leaders representing providers, payers, and consumers – has established goals and a structural foundation for activities, focusing on shared "Triple Aim" goals. Eight building blocks were identified to ensure success, including: connections to community; practice transformation; patient engagement; transparency and reporting; HIT and exchange; workforce; payment reform; and policy and regulatory changes. While goals and activities are expected to evolve over time, initial short term goals identified by the Steering Committee included:

- Improving transitions between care settings, with the goal of enhancing coordination and communication among providers and care settings, and improving performance on key metrics by 20 percent by 2020;
- Reducing unnecessary emergency room visits, with the goal of reducing avoidable ED volume by 10 percent by 2020; and
- Increasing access to integrated physical and behavioral health care services, with the goal of providing 80 percent of Coloradans with access to integrated physical and behavioral health care by 2020.

BC3 supports the SIM initiative, and has purposely aligned its activities with SIM by establishing similar goals. Six of the eight building blocks identified by BC3 match the subject matter areas addressed in SIM Workgroups. BC3's goal around integrated care delivery also matches SIM's stated objective. The SIM Office looks forward to a continued partnership with BC3 as both efforts move into the implementation phase, and is committed to working with other BC3 member organizations to maximize the collective impact of efforts to transform the state's health care system.

Colorado Opportunity Project

The Colorado Opportunity Project is a joint initiative recently launched by CDHCPF, CDPHE, and CDHS to provide low-income Coloradans with economic opportunities for upward mobility and a pathway to the "middle class" that ends their reliance on safety net programs. One of the project's key aims is to create a shared understanding of what opportunity looks like in Colorado and to coordinate and align the efforts of government, private, non-profit, and community partners around that vision to support economic opportunity for Coloradans in a streamlined and efficient way. This includes aligning key state agency initiatives, including CDPHE's 10 Winnable Battles, CDHS's Two-Generation Approach,[53] and

[53] Two-Generation approaches focus on creating opportunities for addressing the needs of vulnerable children and their parents together; CDHS is currently partnering with Ascend/The Aspen Institute to apply Two-Generation approaches in Colorado

CDHCPF's ACC, as well as the Cross-Agency Collaborative on Quality Measurement, to drive progress towards a common goal of ensuring Coloradans have access to economic opportunities.

The goal of the Opportunity Project is to deliver evidence-based initiatives that provide the opportunity for all Coloradans to reach middle class[1] by middle age. To track and measure social mobility and help ensure Coloradans stay on the path towards self-sufficiency and economic success, the Opportunity has developed a set of "indicators," or milestones, across various life stages, from family formation through early and middle childhood, adolescence, the transition to adulthood, and adulthood. Colorado SIM supports the life stages approach adopted by the Opportunity Project, which builds on the Brookings Institution's Social Genome Project framework, as a mechanism for addressing the social determinant of health. SIM's activities to increase prevention and screening for behavioral health conditions will complement the efforts of the Opportunity Project by identifying challenges that individuals face that might negatively impact their ability to meet the selected benchmarks and achieve social mobility during any life stage. In addition, SIM's initiatives to bolster public health and community resources will provide Colorado Opportunity Project partners with a broader range of tools to design interventions, and develop "course corrections" that will allow individuals to continue to progress along that pathway to economic opportunity.

Colorado Office of Early Childhood – Early Childhood Mental Health Strategic Plan

The 2015 Early Childhood Mental Health Strategic Plan (ECMHSP) was developed to serve as a guiding and strategic vision for early childhood mental health efforts in Colorado. This overarching plan encompasses the range of work in Colorado currently focused on social emotional development and early childhood mental health, which will collectively contribute to the plan's outcomes.

The ECMHSP is closely aligned with the 2015 Colorado Early Childhood Framework, developed by the Early Childhood Leadership Commission within CDHS' Office of Early Childhood, and focuses on the domain of health and well-being domain. Building upon previous work in the state, the ECMHSP identifies three priority areas: a sustainable financing approach system, coordination and alignment across system and sectors, and a competent workforce that's well-trained and well supported. Each priority is associated with specific goals, which include improvements at the family, provider and systems level. An outline of the ECMHSP is included in ***Appendix F***.

The SIM Office will work with the Early Childhood Mental Health Director in the Office of Early Childhood to help ensure alignment of goals and objectives around child mental and behavioral health,

and identify ways SIM initiatives can contribute to the achievement of the achievement of the ECMH strategic vision. SIM is also committed to working with the additional state-based organizations, programs, and initiatives engaged in activities related to ECMH, and aligning with and supporting these efforts whenever possible.

Education and School Initiatives Involving Behavioral Health

Colorado's Healthy Schools Collective Impact Project

The Colorado Healthy Schools Collective Impact project, initially spearheaded by the Colorado Education Initiative (CDI), is bringing together a diverse set of stakeholders who are passionate about students, health, and education in Colorado. In order to achieve the vision of a state in which all youth are healthy and reach their full potential, the project has set the goal of all Colorado K-12 public schools providing an environment and culture that integrates health and wellness equitably for all students and staff by 2025. As part of the planning efforts, CDI recruited work group members from nonprofit organizations, businesses, state agencies, schools, and districts from across Colorado, to discuss four key content areas: Comprehensive physical activity, nutrition, behavioral health (social, emotional and mental), and student health services. Moving forward, the Spark Policy Institute will lead strategy development and implementation.

Building Bridges for Children's Mental Health

The Building Bridges for Children's Mental Health Project in Colorado (Building Bridges), housed within the Colorado Department of Education, is designed to build a statewide system to support and sustain the integration of public schools and local behavioral health systems that will lead to increased access to behavioral health services and improved outcomes for school-aged children.

Colorado SIM recognizes that the need for integration is not unique to primary care practices and understands that schools will play a critical role in developing coordinated care systems that will best serve the medical and behavioral health needs of children and their families. The Colorado Healthy Schools Collective Impact and Building Bridges Projects offer SIM an opportunity to partner with a variety of institutions and leaders across the state to engage in this critical work.

Hospital Initiatives

Peaking Patient Engagement – Colorado Hospital Association

The CHA has developed a Peaking Patient Engagement network to support member hospitals in developing patient and family engagement programs. CHA offers educational conferences, toolkits, resources, tailored coaching, site visits, and monthly webinars on four pillars of patient engagement,

which include: 1) engagement in organizational decision-making; 2) engagement in clinical quality improvement and safety; 3) engagement in patient experience improvement; and 4) engagement in their own care.

Colorado Healthy Hospital Compact

The Colorado Healthy Hospital Compact (CHHC) is an agreement by hospitals that share a mission to protect and promote the health of hospital patients and their families as well as visitors and staff. Compact Partner Hospitals have agreed to implement measures designed to improve the quality of their nutrition environments and "lead by example" to develop a culture of wellness that contributes to Governor Hickenlooper's goal of making Colorado "the healthiest state." The Compact, developed by health agencies, non-profit organizations, and hospitals consists of four programs: 1) the Healthier Food Program, 2) the Healthier Beverage Program, 3) the Marketing Program, and 4) the Breastfeeding Policy and Support Program.

Colorado SIM will continue to engage and work with the Colorado Hospital Association and hospitals throughout the state around health care reform efforts, including the patient engagement and healthy nutrition environment initiatives listed above. While the Colorado SIM plan focuses first on enhancing and expanding primary care to include behavioral health services, successful integration, supported by value-based payments, will establish a basic infrastructure to begin creating larger coordinated systems of care, including hospital-based care.

CDHCPF is examining strategies to further expand provider networks under Phase II of the ACC, and to incentivize hospitals to promote a shared, proactive system that improves health and drives innovation. In partnership with the hospitals, CDHCPF intends to explore the feasibility of developing and implementing a DSRIP program as a means for coordinating hospitals with the ACC and engaging hospitals around the vision of accessing whole-person care and creating shared accountability and goals. Colorado SIM will participate in these discussions, and will work collaboratively with CDHCPF, hospitals, and other key stakeholders to develop a coordinated strategy around hospital engagement in alternative payment models.

Component Summary Table

SIM Component/Project Area: *SIM Alignment with State and Federal Initiatives*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Provide platform for coordinating and aligning multiple state and federal initiatives around a shared, statewide vision of health and health care reform	Utilize SIM as an "umbrella" and opportunity to bring statewide initiatives and stakeholders together to promote a shared vision of health	SIM Office	Practice Transformation; Payment Reform; Population Health; HIT	Garner support/consensus around a shared statewide vision of health
Promote information sharing and coordination between state, local, and non-governmental organizations to increase opportunities for alignment	• Use SIM Workgroups as a forum to share information about ongoing initiatives, and identify areas of alignment • Identify similar initiatives and pool resources to increase impact • Coordinate and align regulatory approaches across state agencies • Align program participation requirements, including metrics, whenever possible to minimize reporting burden and reform fatigue	SIM Office	Practice Transformation; Payment Reform; Population Health; HIT	Increased awareness, coordination among multiple state entities and organizations; increased leveraging of available resources
Educate practices and providers regarding prohibitions against using funds from different federal initiatives for duplicate activities	• Include language about restrictions on the use of funds from multiple initiatives in RFPs, RFAs, and other documents • Ensure all vendors/contractors have a clear understanding of the allowed uses for federal funds	SIM Office	Practice Transformation; Payment Reform; Population Health; HIT	Compliance with federal rules and regulation regarding award/grant funds

SIM Component/Project Area: *SIM Alignment with State and Federal Initiatives*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Monitor various federal initiatives in the state, and work to align with SIM goals and objectives	• Maintain ongoing communication with state and national stakeholders engaged in such initiatives, including, but not limited to: - Medicaid transformation efforts, including the ACC and ACC:RMPH Prime (see below) - CPCI (see below) - State Demonstration to Integrate Care for Medicare-Medicaid Enrollees - Medicare Shared Savings Program - Health Care Innovation Awards - Bundled Payment Initiatives - Meaningful Use and HITECH - Initiatives from related federal agencies, including the CDC, ONC, SAMHSA, HRSA, and AQHR (see CCBHC grant below) - Transforming Primary Care Initiative (see below) • Work with CMS and CMMI to align/coordinate the participation requirements for such programs (i.e., align/coordinate milestones, measures, etc.)	SIM Office; CMMI	Practice Transformation; Payment Reform; Population Health; HIT	Coordination and alignment of federal initiatives and SIM

SIM Component/Project Area: *SIM Alignment with State and Federal Initiatives*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Continue to coordinate and align SIM activities with the Comprehensive Primary Care Initiative	• Leverage past payer commitments, investments in practice transformation, and alternative payment models • Include CPCI practices in SIM practice cohorts to share experience, lessons learned, and best practices • Build off IT infrastructure and data collecting and reporting under CPCI • Align SIM practice milestones with CPCI	SIM Office; Multi-Payer Collaborative	Practice Transformation; Payment Reform; Population Health; HIT	Coordination and alignment of CPCI and SIM
Engage with HCPF around the proposed restructuring of the ACC under Phase II and the RCCO rebidding process	• Participate in HCPF discussions with stakeholders • Provide written comments on ACC Phase II Concept Paper	SIM Office; HCPF; stakeholders	Practice Transformation; Payment Reform	Coordination and alignment of ACC Phase II and SIM
Monitor progress of the ACC's Rocky Mountain Prime pilot	Identify lessons learned and best practices that may be applied to SIM practices	SIM Office; HCPF; Rocky Mountain Health Plans	Practice Transformation; Payment Reform	
Participate in HCPF planning around the Certified Community Behavioral Health Center (CCHBC) grant to identify areas of overlap with SIM	• Provide comments on proposed payment strategy • Work to align measures that will be used under CCBHC with SIM minimum dataset • Coordinate workforce strategies (assessment, training) for CCBHC with SIM activities	SIM Office; HCPF; stakeholders	Practice Transformation; Payment Reform	Coordination and alignment of CCHBC and SIM
Work with the Colorado Collaborative for Practice Transformation on planning and implementation activities for the Transforming Clinical Practices Initiative (TCPI)	Participate in all relevant meetings related to TCPI	SIM Office; Colorado Collaborative for Practice Transformation	Practice Transformation; Payment Reform	Coordination and alignment of TCPI and SIM

SIM Component/Project Area: *SIM Alignment with State and Federal Initiatives*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Monitor various non-federally funded initiatives in the state, and work to align with SIM goals and objectives	• Maintain ongoing communication with state stakeholders engaged in such initiatives, including, but not limited to: - Regional health care collaborative - Community benefit programs - Local public health departments	SIM Office	Practice Transformation; Payment Reform; Population Health; HIT	Coordination and alignment of non-federally funded initiatives and SIM
Conduct continued outreach to trusts, foundations, and other philanthropic organizations to remain informed of other state initiatives involving integrated care and alternative payment models	Engage and coordinate with projects/initiatives focused on underserved populations and populations with special needs, such as LTSS, early childhood mental health, school programs, the homeless, etc.	SIM Office	Practice Transformation; Payment Reform; Population Health; HIT	Coordination and alignment of state initiatives around efforts involving integrated care and payment reform

Workforce Development Monitoring

Workforce Capacity

Healthcare Workforce in Colorado

In 2014, Colorado was one of seven states selected by the NGA to implement a health workforce development plan that will create a centralized data and analytics hub, use data to drive statewide workforce planning that is responsive to local needs, and build on Colorado's nationally recognized loan repayment program to expand recruiting and retraining efforts. We recognize that the future workforce will be uniquely positioned to address the needs of the redesigned healthcare system, and that the current workforce needs to be repositioned and retrained to flex with the ever changing healthcare environment. Nowhere is there more a critical need to modify how we train our providers, and what we expect from them than within our behavioral health and primary care workforce.

Integrating behavioral health and primary care requires a different type of workforce; a workforce that understand what it's like to work as a team in settings that are often different than those they were trained (e.g. mental health providers working in primary care). Bridging the gap between disparate training cultures to align into a cohesive unit takes time and requires that each of the respective providers understand their role in a newly redesigned setting. Truly, integrating behavioral health and primary care is a fundamental disruption of the traditional training paradigm.

The Governor's Office will work with the Colorado Department of Higher Education (CDHE), the Colorado Community College System (CCCS), and key health professions' educators to ensure that team-based, integrated care delivery is a training priority. Creating a common curriculum that trains our workforce to understand how to work together is essential in achieving success for Colorado and for Colorado's innovative healthcare delivery strategies.

Colorado is also committed to developing policy and regulatory supports for all providers who can help leverage our primary care workforce. A Governor-appointed, inter-professional task force is currently finalizing its findings from a healthcare workforce specific academy held over the summer of 2015. The Colorado SIM workforce workgroup has met with the Governor's workforce cabinet to gain critical feedback on the proposed outcomes for the group, and will continue to relay information to the Governor's cabinet throughout the course of the test phase in order to ensure alignment of efforts with existing initiatives throughout the state.

Workforce Capacity

Disproportionate Distribution of Workforce in Rural and Frontier Areas

Colorado SIM will work to develop and implement strategies to meet the need for medical and behavioral health personnel around the state. This includes an assessing the workforce needed to meet the clinical and non-clinical demands of providing integrated care, such as IT, administration and billing, discharge planning, and health navigator services. The targeted outcome of this effort is to create learning opportunities for both primary care and behavioral health providers to understand how to best work with one another in both settings. Integrating providers requires addressing workplace culture; as such, Colorado SIM will offer opportunities for providers for team-based training, both in educational and "real world" settings.

CDPHE is in the process of creating a master provider directory for the state, which will include a widely expanded set of data from what is currently collected through the provider licensure process. Participation in the provider directory will be voluntary during the pilot phase, but CDPHE plans to work with policymakers and the SIM workforce workgroup to ensure the capture of accurate and complete data. This accurate data set will strongly enhance the state's ability to refine workforce initiatives in the state by defining specific workforce and training needs.

In addition, a set of core competencies needs to be established for this integrated team. Currently, multiple efforts are occurring within the state to develop a set of core competencies for professionals working in an integrated care setting. These efforts are aimed at both the primary care setting and behavioral health setting (community mental health centers). The University of Colorado and CBHC have made progress in identifying professional competencies. The SIM Office will continue to serve in a leadership capacity, to facilitate discussion and encourage ongoing cooperation and coordination of these efforts.

Professional licensing standards dictate the minimal criteria for competencies for behavioral health providers working in primary care, in addition to any new competencies a practice should choose to adopt. New competencies that are being created for BHPs working in primary care do not attempt to re-create the entire scope of competencies for licensed behavioral health providers acquired in their basic training – only the competencies specific to working in primary care that may or may not stand out beyond those expected of licensed behavioral health providers in general. Some competencies will likely be learned through formal education in classes or on the job, while new competencies are developed and mastered as the behavioral health provider acquires reflective experience in an integrated primary

care setting. The SIM Office will continue to serve in a leadership capacity to facilitate discussion and encourage ongoing cooperation and coordination of these activities.

The aforementioned training, research, and collaboration efforts will be supported by academic partners through the identification of opportunities for resource leveraging with the CDHE and CCCS. The SIM Workforce Workgroup will create a set of best practices for integrated care training for both current and future providers and implement these changes with the collaboration of institutions of higher education and the relevant government agencies responsible for them.

To some extent, there are an unknown number of individuals working in positions that are outside regular job categories in the Standard Occupational Classification (SOC) system used by Federal statistical agencies to classify workers. This includes any number of contract, temporary, and some in the unlicensed or paraprofessional workers. For any occupation, the Colorado Department of Labor and Employment's (CDLE's) Office of Occupational Employment Statistics reviews knowledge of the work performed, education level, and experience required, and assigns an SOC code to a job. The likely majority of jobs are categorized within a particular SOC code.

However, in the health care profession, health care executives have articulated the dynamic nature of the profession, and the creation on new positions in response to market demands, technological changes, and changes to the health care system as a result of the Affordable Care Act. Through Health and Wellness Sector Partnerships, we know that healthcare providers have newly created positions with similar responsibilities and the demand for these positions are increasing. These demands are not currently captured in Labor Market Information (LMI data). For instance the Northern Colorado Healthcare Sector Partnership engages over 50 healthcare employers across Weld and Larimer Counties. The partnership estimates that they will collectively have over 300 medical assistant openings over the next two years while LMI data projections indicate that there will be just over 30 openings from 2015-2025. Healthcare providers are working in partnership with education and workforce partners to address the challenges of new demands in the dynamic healthcare field. The staff in Colorado's workforce centers closely monitor LMI and other data in order to understand the demand and supply in this workforce sector.

In addition to providing data analysis, Colorado has been at the forefront of using sector partnerships to better understand the current needs of industry and in-demand occupations. Colorado defines sector partnerships as an industry-led effort that collectively defines common opportunities and challenges,

and connects businesses with workforce, education, and economic development partners to create solutions that improve the businesses' bottom line. CDLE has a number of active Health and Wellness sector partnerships throughout Colorado which have helped identify current workforce demands. This helps bridge the divide between the easily recognized occupations and new or emerging occupations across the industry.

The Colorado Workforce Development Council (CWDC) is the statewide convener for sector partnerships and career pathways. The CWDC, Colorado's workforce development board, is responsible for the continuous improvement of the workforce system, oversight of Workforce Innovation and Opportunity Act funds, and ensuring a statewide strategic vision created from the bottom up through Council members and local partners. It is through these active sector partnerships, led by industry (multiple businesses from healthcare working together) in partnership with education, economic development, and workforce development, allows for a deeper and more current understanding of in-demand occupations. With this information a plan of action can be developed to build a responsive career pathway system to meet the needs of the health industry help individuals secure a job.

Pipeline issues

While Colorado has a fairly robust capacity for primary care and behavioral health service delivery in its most populous urban regions, the remainder of the state faces shortages, long wait times, and prohibitive commutes for care. These issues must be addressed in order to achieve health equity and to support integrated care models statewide. This transformation will require creative innovations in the delivery system that allow for a placement for these newly trained providers.

Lack of Alignment in the State

The SIM Office has attempted to align the efforts of various workforce stakeholders to mitigate any duplication or confusion. For example, The University of Colorado's statewide workforce conference attempted to invite leaders from throughout the state's training/education community. The SIM Office will continue to work to influence and align the efforts of organizations and agencies engaged in designing training programs, and hopes to organize a statewide summit of training programs to help ensure that duplication of efforts is kept to a minimum.

Many groups in the state are currently engaged in identifying and solving workforce issues. SIM will align efforts wherever possible with existing organizations that share the vision of the Colorado Framework for integrated care, and work with these partners to collectively achieve the Triple Aim of lower costs, better access to care, and improved population health. Colorado SIM has plans to reach out to many

agencies to align efforts in 2016, including the Colorado Commission of Family Medicine, a collaborative model for providing primary care to the people of Colorado. Colorado SIM has already endeavored to align efforts with the following agencies and will continue to identify important areas for collaboration over the course of the model test:

DORA and the OBH: Keeping professionals and consumers protected through regulation and licensing. Colorado SIM is coordinating with DORA and OBH to communicate the desired outcomes of efforts related to provider competencies and practice transformation. SIM has a positive and open line of communication with DORA and OBH so that barriers to integrated care can be discussed. Both offices are dedicated to coordinating messages and pursuing activities that will support and advance SIM goals and objectives to a reasonable degree.

CDHCPF: CDHCPF's Colorado Opportunity Project aims to provide supportive services to Coloradans for success in key life stages with the intended outcome of long term physical and financial well-being. An integrated healthcare workforce is able to support this program by identifying behavioral and physical health conditions at all life stages and properly diagnose and treat these conditions so they do not become long-term barriers to well-being.

ACC Improvement Committee: Providing recommendations to help improve health, access, cost, and satisfaction of members and providers in the ACC. The SIM Workforce Workgroup will review the findings and recommendations of the ACC Improvement Committee and use their vision as a frame for creating policy recommendations.

The BHTC: Working to reduce the economic and social costs of untreated behavioral health disorders through coordinated health system transformation. The SIM Workforce Workgroup hosts a member of the BHTC in its membership. The two agencies are working to align efforts.

The CWDC: CWDC, the state workforce development board, is an industry led coalition of businesses and public partners representing multiple industries and state agencies. The CWDC is charged with aligning the efforts of economic development, workforce development, education, government, and business stakeholders at the local, regional, and state levels to ensure businesses have access to a talented workforce and students and job seekers have access to meaningful employment resulting in statewide economic vitality. CWDC does this through convening regional industry led sector partnerships that address opportunities such as: developing the current and future development of talent, creating industry led of career pathways, and identifying business needs related to legislative and

regulatory changes. SIM is partnering with the CWDC and the network of health sector partnerships and will be participating in bi-monthly statewide peer networking calls with regional healthcare sector partnerships in order to gauge health care business needs around the state.

CDLE: Within CDLE, the Divisions of Employment and Training and Labor Standards and Statistics work closely with CWDC and the networking of Colorado Sector Partnerships to address workforce development and training needs around the state.

The NGA Healthcare Workforce Academy: Setting the stage for workforce development in Colorado through analyzing industry trends and workforce needs in the state. SIM will be in communication with the NGA Health Care Workforce Academy and keep them abreast of any developments in their work.

CHW/PN Enhancement: A multi-agency effort to grow a diverse and robust workforce. CHW and PN opportunities are simultaneously opening doors to higher education and improving population health. The state has multiple conversations taking place at institutions of higher education, workforce groups, and government agencies around the competencies these occupations should follow, whether or not they should be subjected to regulation, and various other issues. Colorado SIM will align efforts while keeping the Triple Aim as its primary objective. A subgroup of the Workforce Workgroup is completely dedicated to navigating the unlicensed workforce and will make policy recommendations based on their findings.

Leveraging SIM to Develop and Align Colorado Workforce Initiatives

Stakeholder Engagement

The SIM Workforce Workgroup includes representation from members of the primary care, behavioral health, policy making, community interest, workforce development partners, and academic communities. Additionally, the workgroup will leverage opportunities for data strengthening, stakeholder engagement, and collaboration with state agencies and health care workforce sector partners through the CWDC. The group brings a diverse wealth of knowledge to the table, and workgroup meetings are rich with influence from multiple fields. The group's primary goal is to influence policy and work to ensure adequate training and workforce recruitment is taking place.

The Workforce Workgroup has created three subgroups to identify barriers to integrated care: the Unlicensed Health Care Workforce Subgroup, the Future Workforce Pipeline Subgroup, and the Current Workforce Subgroup:

Current Workforce

The Current Workforce Subgroup will make training and policy recommendations to support the transition into integrated care. The University of Colorado, along with its supporters, hosted a conference in November 2015 to identify key competencies for the integrated care setting. The findings will be published and considered by the workgroup as it makes its recommendations.

Future Workforce

The Future Workforce Subgroup will identify existing and recommend additional tuition incentives for working in an integrated care setting and rural and frontier areas, as well as commit to making training adjustments to ensure a culturally competent workforce.

Unlicensed Workforce

The unlicensed subgroup is dedicated to finding ways to enumerate and clearly define competencies for the unlicensed workforce in Colorado. Strong collaboration and communication will take place in order to ensure an effective and aligned set of policy recommendations come out of this workgroup.

The subgroups plan to meet and conduct research offline, and provide recommendations to the greater Workforce Workgroup and the SIM Office.

Colorado SIM Workforce Priorities

Colorado SIM has identified a number of initiatives for future work to advance health workforce priorities specifically related to SIM. These priorities include:

Increase Colorado's Base of Workforce Data to Aid Decision-Making

The Workforce Workgroup will work with the CDLE, CWDC, CDPHE, and others on collecting data to assist the current healthcare workforce in integration efforts. Collecting this data will also help Colorado SIM influence health care industry leaders as implementation begins to take place. The strategies for this effort include:

- Collecting research-based assessments and developing a set of best practices for integrated care teams;
- Gathering data on the current level of training obtained by most providers preparing them for the integrated care setting;
- Gathering data on the appropriate panel to size care models, and making recommendations to other workgroups based on the data analysis;

- Collecting data on the non-clinical needs of practices, specifically IT needs, and presenting this data to the relevant work groups; and
- Gathering data to assess the scope and level of training necessary to prepare all SIM partner providers for the integrated care model.

Strengthen the Colorado Health Care Workforce Pipeline

The Colorado SIM is dedicated to working with its academic, industry, and health care workforce sector partners toward supporting a robust and competent future workforce. This effort involves being geographically inclusive when making recommendations that will affect future training efforts in the state, as well as considering where personnel shortages are most desperate. The educational climate is currently preparing for the integrated care concept. SIM is working toward finding opportunities to increase scope of practice where it serves the integrated care consumer, creating enhanced occupational diversity, and making recommendations to educate future workforce personnel to treat the whole person. Objectives related to this effort include:

- Partnering with CWDC and the network of health sector partnerships to better understand the regional needs of healthcare businesses;
- Partnering with educational institutions to identify appropriate measures for defining competencies and training personnel to achieve high performance in an integrated care setting;
- Fostering the relationship between higher education and rural area health providers;
- Enhancing the capabilities of the unlicensed health care workforce by identifying gaps and working with the academic community to train with these identified needs in mind;
- Continually evaluating recruitment and retention efforts, adjusting when necessary, and using data to target resources;
- Focusing on master degree level licensed providers and being inclusive of their talents in the integrated care setting (e.g. (Licensed Addictions Counselors, Licensed Professional Counselors) etc.; and
- Providing cross training on issues that may require specialty care, such as SUDs.

Provide Ongoing Leadership

The Colorado SIM Office is dedicated to serving in a leadership capacity for state workforce initiatives, industry partners, and academic institutions looking to support the integrated care model. Leadership at this level involves collaboration, clear communication of objectives, and strong technical assistance.

The Workforce Workgroup includes representation from leaders in both industry and academia. In partnership with the SIM Office staff, the Workforce Workgroup aims to accomplish the following:

- Create opportunities for both primary care and behavioral health providers to learn how to best work with one another in both settings;
- Serve as the voice for the rural health care providers in the state and be inclusive of their issues while making recommendations to relevant workforce groups;
- Develop a plan for change management before, during, and after the innovation roll-out that will engage providers, administrators, and educators;
- Work closely with the Practice Transformation Workgroup to inform the Workforce community on updates to payment structure so that they may consider the impact of these changes in their change management plans for integrated care;
- Use the Health Extension Services model to engage whole communities and connect practices and providers with regional and statewide resources and guidance, including Regional Health Connectors; and
- Address policy barriers related to workforce innovation.

The Colorado SIM Workforce Workgroup has a primary objective of making policy recommendations that affect its area of expertise. The following policy related items will be considered by the group and recommendations will be made as needed:

- Conducting a comprehensive review of current Colorado health professional practice acts and statutes regarding provider credentialing, empanelment, and related issues;
- Identifying the challenges that current licensing, credentialing, record keeping, disclosure requirements, and other standards pose to collaboration among specialties;
- Assessing the workforce required to meet both clinical needs and non-clinical needs, such as IT, administration and billing, discharge planning, and health navigator services;
- Developing and applying for a Sales and Purchasing agreement to create Section 2703 health homes and incentivizing contractual and financial alignment between Colorado's RCCOs and BHOs; and
- Creating state level standards-based interoperability requirements.

Leverage Local Technology, Innovation and Leadership

Leveraging resources is an integral part of realizing Colorado SIM's objectives. In order to meet the following objectives, the Workforce Workgroup will utilize the expertise and resources of other workgroups and agencies:

- Having a standardized curricula and approach to certification and credentialing of lay workforce. This will involve overcoming regulatory and industry barriers;
- Advancing Telehealth Technology. This work requires coordination with the HIT workgroup;
- Supporting state-driven support and funding for HIT and HIE adoption, including appropriate exchange of behavioral health information to improve care; and
- Leveraging HIT infrastructure for use within and beyond the health system, including Colorado's state marketplace, eligibility services, provider directories, prescription drug monitoring, health condition registries, and other social and public health programs.

Proposed Outcomes

The following are the proposed outcomes of Workforce Workgroup, as outlined on the component table. In order to meet these objectives, the Workgroup will work closely with the CWDC and the network of health sector partnerships throughout the state. These outcomes support the project components, the Triple Aim, the Colorado Framework, and the State of Health Plan, and align with the efforts of other groups in the state:

- Report out on: A Colorado Consensus Conference: Establishing Core Competencies for Behavioral Health Providers Working in Primary Care.
- Work with industry partners to begin a method for enumerating the unlicensed workforce in the state.
- Perform environmental scan of practices, training and education programs, and workforce partners throughout the state to understand their respective activities for integrated care and create a map of these efforts.
- Generate policy recommendations as they relate to health workforce innovation throughout the state.
- Report out on Workforce Workgroup progress at the SIM annual conference.

Legislative, Regulatory and Executive Actions

Influencing Policy

The Workforce Workgroup will work with the Policy Workgroup to develop and implement policies that supports the Colorado Framework and the Triple Aim through thorough research, alignment with current workforce efforts in the state, and cultivation of subject matter expertise. SIM will serve as a leader in Colorado's workforce arena by creating best practices for integrated care, and influencing the course of the workforce standards, training, and pipeline in the state. SIM will work closely with CWDC and the network of health sector partnerships to understand the workforce standards, training, and pipeline needs at the regional level.

Legislative Actions

The shortage of health care personnel in rural and frontier areas incited the Health Professional Loan Repayment Program (SB 07-232). CDPHE is currently creating a provider directory that would more clearly define workforce need in the state by collecting practice specific data, including scope of practice, patients served, etc.

The Workforce Data bill (HB 12-1300) implementation was completed by DORA in July 2013 in coordination with at CDPHE and included a selected subset of questions to the existing Health Professionals Profile Program (HPPP) database. These questions are voluntary and attached to appropriate license types; OIT and the DPO developed a reporting service for CDPHE to access the data. DPO is in continued contact with CDPHE in the event that any questions arise or they request change. Since implementation DPO received input from CDPHE to adjust wording of some questions and completed updates in the spring of 2014.

The collection of up-to-date information about current workforce capacity and distribution may identify new or changing patterns that could increase the number of students eligible for the Health Professional Loan Repayment Program. SIM is also exploring the option of creating additional student loan assistance programs, to incent providers willing to work in certain areas in the state or in certain fields with high need for personnel.

The SIM Workforce Workgroup is considering the Provider Directory and the requests of the Governor's Workforce Cabinet when considering policy recommendations that will impact the health care personnel placement in the state. A statutory change recently went into effect as part of a recommendation by the Governor-appointed Nurse-Physician Taskforce for Colorado Healthcare making

it easier for advance practice nurses to gain independent prescriptive authority. Issues like these are being addressed within the Workforce Workgroup, and the expertise of state regulatory authorities are being called upon for assistance as the group drafts its recommendations.

Regulatory Actions

One of Colorado SIM's objectives around workforce involved ensuring that state regulatory and oversight structures facilitate the development of integrated care delivery models. During the planning period for the model test award, a number of regulatory provisions regarding provider and facility licensure were identified as posing a barrier or impediment to the delivery of integrated physical and behavioral health. SIM will work with state agency partners and other stakeholders to develop strategies in the following areas.

Licensure

The issue of licensing is two-fold, as there are regulatory barriers for both individuals and facilities when it comes to providing integrated care. The implications of integrated care could potentially require regulatory change due to the need for PCPs to perform at the top of their licensure.

The same issue exists for Behavioral Health Providers (BHPs) integrating into primary care. Cross-training in behavioral health competencies may create barriers for PCPs wishing to add to their skillsets with the intent of providing better triage services for their patients in an integrated care setting. BHPs are able to practice in integrated care settings, covered by their individual licenses. The same goes for PCPs wishing to practice inside of a CMHC. No special licensure or regulation is required. The exceptions to this are specialized substance abuse disorder practitioners administering controlled substances, such as methadone, those facilitating DUI follow up, or those working with incarcerated persons. These professionals are required to work in facilities with special licensure.

The other situation that would pose a regulatory barrier would be if a facility wanted the authority to place holds on its patients. Facilities with this authority must possess a 27-65 designation. CMHCs must have this designation, which is regulated by the OBH.

The Workforce Workgroup will work closely with the Policy Workgroup in regard to data sharing barriers within an integrated team as they relate to 42 C.F.R regulations. For more information about the regulatory and legal barriers to integrated care, see the ***State and federal privacy policies, standardized consent forms, and data use agreements*** subsection of the ***Leveraging Regulatory Authority*** section of the Operational Plan***.***

Provider Training

Both the current and future workforce in Colorado will need training to be able function efficiently and effectively in a team-based, integrated care delivery setting. Colorado SIM will work with a variety of partner organization to develop and coordinate training programs in a variety of settings. Anticipated activities in this area include:

- Leveraging the Health Extension System currently under development to connect providers to training resources; and
- Using SIM as a platform to launch or coordinate a statewide campaign to educate providers on incorporating a behavioral health specialist in primary care practices.

SIM is in communication with DORA, as well as the BHTC, the CWDC, and the NGA Workforce group to align visions on the integrated care model, come to a consensus about the best methods for creating a workforce that can support and maintain the expansion of integrated primary and behavioral health care delivery models, and identifying barriers may stand in the way of such efforts.

Executive Actions

The BHTC was formed by Executive Order; the CWDC, formed through federal legislation, is mandated by executive order and state statute to be the coordinating and convening body that works to align workforce development, economic development, education, and government at the state, regional, and local levels. These two groups are dedicated to solving complex workforce issues throughout the state. The BHTC Workforce Subgroup Chairperson sits on the SIM Workforce Workgroup, is involved in conversations regarding competencies for integrated care, and is providing input at multiple levels of the SIM Workforce initiative. CWDC and SIM are working closely together to inform employers about SIM and get their valuable feedback regarding the demands of the industry.

In addition to these efforts, the Workforce Workgroup's goals and projected outcomes are being reviewed by the Governor's Workforce Cabinet to identify key intersections with other programs in the state, and pursue possible course corrections if any duplication of efforts is identified.

Documentation of Health Workforce Capacity Programs

Please see ***Appendix G***.[54]

[54] CDPHE Primary Care Office. (2014).*Colorado Health Workforce Development Strategy, 2014*. CO: CDPHE, Referencing Appendix F

Component Summary Table

SIM Component/Project Area: *Workforce Development*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Participate in Colorado Consensus Conference.	Participate as a supporter of the Colorado Consensus Summit on defining competencies for integrated care. A book of findings will be published.	Eugene S. Farley Health Policy Center, Rose Foundation, Piton Foundation, SIM Office, CU School of Medicine, Caring for Colorado Foundation, Walton Family Foundation, Colorado Health Foundation.	**Population Health/Practice Transformation:** Participate and support the efforts of CU School of Medicine as they work with academic leaders to define core competencies for integrated care.	Will occur in November 2015.
Meet with Governor's Workforce Cabinet.	Meet with the Governor's Workforce Cabinet to agree upon goals for the SIM Workforce Workgroup.	None	**Population Health/Practice Transformation:** Getting feedback on goals to use for workgroup strategy.	Meeting regularly and communicating with the Governor's Workforce Cabinet on goals and outcomes.

SIM Component/Project Area: *Workforce Development*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Participate in the Colorado Workforce Development Council's Healthcare Sector Partnership monthly check-in calls	Call in to provide a SIM update for the regional health care sector partners and take note of the region specific health care workforce issues from around the state.	None	**Population Health/Practice Transformation:** Staying up to speed on what is going on at a regional level, what their needs are, what challenges they are facing, etc.	Collaborate with the CWDC team, and find opportunities to work with the Sector Partnership Leads
Work with the NGA on adopting workforce collaboration guidelines	Participate in the NGA update calls and apply the upcoming guidelines to the workforce workgroups.	None	**Population Health/Practice Transformation:** Follow up with the Governor's Senior Health Policy regularly, and disseminate the information produced from the Workforce Academy findings to the Workforce Workgroup	Seek an update on the NGA findings bi-weekly until they are released
Utilize the new CDPHE Provider Directory and make recommendations to practices and other workgroups based on its functionality	Participate in update calls within CDPHE regarding the progress on the provider directory.	None	**Population Health/Practice Transformation:** CDPHE Provider Directory could help identify key areas for pipeline focus in the state	CDPHE staff to give presentation at Workforce Workgroup meeting on December 1, 2015
Participate in statewide discussions about unlicensed workforce	Work with CDPHE, CWDC, academia, and DORA to follow conversations on unlicensed workforce	None	**Population Health/Practice Transformation:** Identifying competencies for integrated care within the unlicensed workforce.	Attend CDPHE events regarding this topic and keeping the Workforce Unlicensed Subworkgroup informed.

SIM Component/Project Area: *Workforce Development*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Maintain relationship with DORA	Keep an open line of communication with DORA and ask questions while drafting policy recommendations. Collaborate with DPO Licensing Boards	None	**Population Health/Practice Transformation:** Identify policy and regulatory barriers to integrated care; address issues as they arise	Continue to provide opportunities for updates in our newsletter and discuss regulatory barriers to workforce with DORA
Research leveraging opportunities for enumeration of unlicensed workforce	Work with CDPHE and HCPF to determine status of current enumerated efforts; coordinate future enumeration activities	Not yet identified	**Population Health/Practice Transformation:** Enumerate unlicensed workforce personnel in Colorado	Open conversation with CDPHE, DORA, and other agencies about enumerating unlicensed workforce

Health Information Technology Plan

Colorado SIM will target strategic technology initiatives to promote data-driven change, gauge impact, expand services beyond traditional clinical settings, and facilitate collaboration between payers, providers, and the public health system. In doing so, Colorado SIM will build upon existing synergies between public and private agencies to advance a comprehensive HIT strategy, which includes development and implementation of:

- An enhanced practice assessment tool, called the Shared Practice Learning and Improvement Tool (SPLIT);
- Quality Measure Reporting Tool (QMRT), which will fulfill early-phase SIM and practice-level quality measure reporting needs;
- Identification of SIM "All-Star" practices and/or programs, consisting of:
  - Organizations that can broadly incorporate and demonstrate SIM concepts; and
  - Systems that are capable of sharing quality data to a data hub;
- Data collection and data quality process and infrastructure, which will:
  - Focus on SIM measure sets; and
  - Create bi-lateral feedback with data sources;
- A Central Data Hub (QMRT+), which will:
  - Accept patient-level measurement data;
  - Aggregate clinical and behavioral health data from measure sets;
  - Extend the early phase QMRT tool capabilities;
  - Provide granular data sets by provider, payer, patient, condition, etc;
  - Fulfill Public Health usages;
  - Allow for linkage to claims data and the All Payer Claims Database (APCD) to provide centralized clinical and cost data support;
- Support for SIM All-Stars and advanced value based payment models; and
- A Telehealth Strategic Plan, which will support improved access to broadband and creation of telehealth resource centers as key elements of innovation.

Key Activities:

The following key components of the SIM HIT Strategy were developed by members of the SIM HIT Stakeholder Workgroup in conjunction with the SIM Office and other partner agencies (for more information on the HIT Workgroup, see the ***Governance*** section of the HIT Plan). Additionally, once basic elements of the HIT strategy were identified, the SIM Office, via HCPF procurement, issued a Request for Information (RFI) in anticipation of releasing an RFP in early 2016 for vendors to implement the strategy. The purpose of the RFI was to solicit interest in this work as well as offer potential bidders the opportunity to make recommendations regarding the proposed strategy and approach to completing this work. The SIM Office received over 30 responses to the RFI, which have been used to refine the key components of the strategy outlined below.

Enhancement of Practice Assessment Tool

Tools, processes, and data collection methods are currently utilized to support practice transformation and advancement activities; however the need exists to standardize, enhance, and make these tools more easily accessible. The SIM HIT strategy includes development of a common tool, now called the Shared Practice Learning and Improvement Tool (SPLIT), which can be used for SIM and other statewide projects.

Specifically, the SPLIT will offer web-based access to data entry and reporting related to:

- **Application to programs:** Collecting information to evaluate practice eligibility and readiness for transformation, advancement, quality improvement, or alignment with other programs;
- **Benchmarking:** Collecting assessment and transformation information for baselines, to be used by both the practice and the practice transformation organization in planning next steps in their transformation work;
- **Improvement:** Collecting information on practice improvements over time, for use by the practice, the practice transformation organizations, and program evaluators; and
- **HIT usage**: Collecting information on data quality, systems usage, etc.

Current Status and Next Steps

The University will lead efforts to develop the SPLIT, which will enable SIM practices, practice transformation organizations (PTOs), Regional Health Connectors (RHCs), and the SIM Office to access a common platform for the collection, storage, and dissemination of information to support the integration of primary care and behavioral health as well as the transition to value-based payment models. A subgroup was formed within the SIM HIT Stakeholder workgroup to define requirements for the SPLIT. Pending CMMI approval, the University will use these requirements and contract with a vendor to develop the tool. The University was chosen to lead development of the SPLIT due to its expertise in developing and using similar tools, ability to build the tool before the start of Cohort 1 practices in February 2016, and future reliance on the SPLIT for automating key operations necessary for practices, PTOs, and administrators participating in SIM.

The core functions of the initial version of the SPLIT will include:

- A secure web-based portal able to authenticate users and organize content based on user privileges that vary across users;
- Facilitation of the distribution, collection, and organization of the following reports:
    - Practice Application;
    - Practice demographics;
    - Medical Home Practice Monitor;
    - Clinician and Staff Experience Survey;
    - Integrated Practice Assessment Tool;
    - SIM milestone activity inventory;
    - Practice Implementation Plan; and
    - Practice Data Quality Improvement Plan;
- Import, storage and analysis of data received from practice applications collected using RedCap for the first cohort of practices;
- Tracking submitted reports and a summary report of report statuses; and
- Entry and retrieval of field notes from CHITAs, practice facilitators, and RHCs.

These core functions will be operational by January 31, 2016. In SIM budget year 2, the University will further refine SPLIT's core functions to improve the user interface, develop reports, expand capacity to integrate with other data systems, and aggregate and securely transfer data to evaluation contractors as needed.

Quality Measurement Reporting Tool (QMRT)

The initial QMRT will serve as a portal through which SIM-participating practices and PTOs will enter data related to required practice CQMs and receive feedback on their performance in relation to these requirements. In developing the tool, Colorado SIM, in conjunction with the chosen vendor, will:

- Identify required elements that make up a specific CQM;
- Refine the dataset(s) that practices are required to share related to SIM Measure sets;
- Determine how to recognize and address data quality issues; and
- Define requirements for CQM reporting.

Using this information, the chosen vendor will develop a solution that includes the following features and capabilities:

- An electronic interface for manual reporting and data entry;
- An electronic interface to support defined format electronic submission of practice measures;
- Data storage and normalization capabilities;
- Ability to provide user performance reports;
- Reports for practices, PTOs, and the SIM office that provide a baseline status related to CQMs and tracks changes in relation to this baseline over time; and
- Other reports related to practice-level measure collection.

Current Status and Next Steps

Colorado SIM intends to utilize an initial simplified version of QMRT with the first cohort of primary care practices, which will begin their transformation efforts in February, 2016. While the more robust QMRT+ solution, described in the next section, will eventually become the key element of a larger Central Data Hub concept, the complexity of designing and implementing this solution precludes completion of the QMRT+ by the time the first cohort of SIM practices launches. As a result, Colorado SIM will leverage the vendor for the SPLIT to build a short-term basic QMRT solution. The short-term solution will, at a minimum, include an electronic interface to capture numerator and denominator data at a practice-level data for the SIM CQMs defined for the first cohort of practices. A report that provides

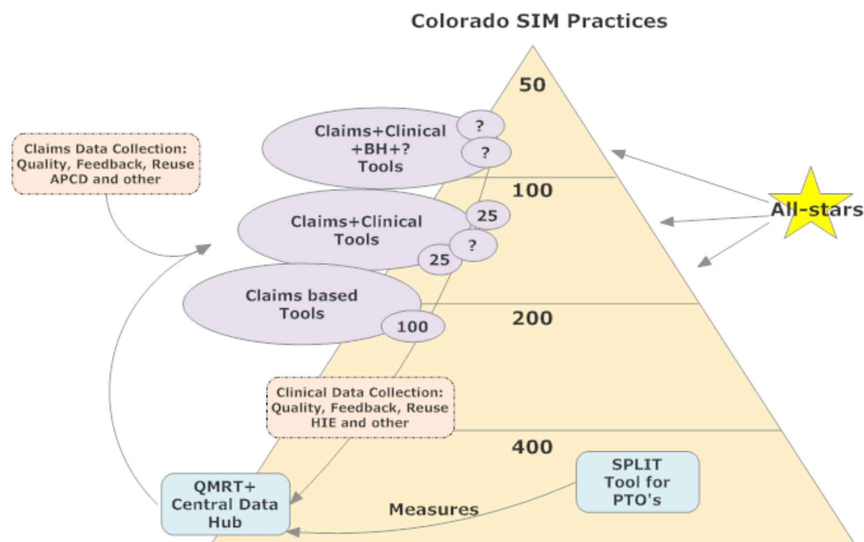
a baseline assessment of performance related to CQMS will be returned to participating practices, PTOs and the SIM Office. The QMRT may be a component or module included in or integrated with the SPLIT.

SIM All-Stars

An important component of the Colorado IT strategy is the concept of SIM All-Stars -- practices, organizations, and programs that achieve advanced levels of practice improvement, systems and data usage for measurement and improvement, and data sharing. The All-Stars will be selected as a subset of the larger 400 primary care practices that undergo SIM practice transformation efforts. The SIM All-Stars will be more aligned for value based payment structures and programs and by participating in these programs will receive the additional value necessary to offset the burden of change and resources often required.

Current Status and Next Steps

Potential SIM All-Stars will be identified collaboratively with the HIT group and the other SIM groups. Once selected, the All-Stars will be phased into the HIT plan and aligned with the other HIT objectives of the overall plan according to needs. Some All-Stars might use claims-based population tools, while others will utilize more advanced claims and clinical data integration. The SIM HIT plan will reflect the support required for the differing needs once the All-Stars have been identified. The following diagram outlines the phased participation of SIM practices in various elements of the HIT strategy, including the participation of SIM All-Stars in advanced data sharing.



The SIM All-Stars concept is currently being developed in conjunction with multiple SIM Workgroups - including Practice Transformation, Workforce, Population Health, Policy, and Payers - and will leverage and expand upon previous federal and state investments in information technology projects. At this time, the SIM Office anticipates that practices selected as All-Stars will play a leading role in expanding or enhancing the use of tool that exist at multiple levels: 1) claims-based tools; 2) tools that combine claims and clinical data; 3) tools that combine claims and clinical data with behavioral health data; and 4) advanced "care coordination" or other tools.

Although the All-Stars concept is still in a nascent state, the SIM Office envisions that the following types of projects or efforts might be undertaken by All-Star practices:

1) A group of CPC practices might be supported to move from using just claims data in the Stratus tool to also incorporating clinical data into the tool as well. Along with the obvious claims and clinical data combination this usage could also showcase data quality in practice, data acquisition, data reuse, etc.
2) FQHCs as part of CCMCN might be supported to show how they can utilize and benefit from external measurement tools and incorporate community-based care coordination concepts leveraging the data.
3) ENSW or other programs show how they incorporate claims data into the clinical data being obtained or how they expand BH data usage.
4) A group of CAII practices show how to leverage CCD data acquisition to share data with the QMRT+ and test if that data can be accurately used for measurement (again data quality, acquisition and reuse concepts).
5) Practices involved with TEFT leverage data quality and acquisition concepts inherent in SIM for data to the TEFT tool.
6) Former Beacon practices begin to use claims data in a tool like Stratus.
7) Community based care collaboration programs (LPHA, Social Service, LTPAC, Primary Care, etc.).

Data Acquisition and Aggregation with QMRT+ Central Data Hub

The foundational building blocks of the QMRT+ Central Data Hub will be the acquisition and initial aggregation (or staging) of high-quality clinical and behavioral health data related to the SIM measure sets. The initial data will consist of the basic CQM data aggregated through the QMRT outlined above. As practice transformation efforts improve provider capacity to produce, share, and report on data, opportunities for data acquisition will also expand from basic measure data to include patient-level and

more granular data sets. Additionally, as new cohorts of SIM-participating practices come on board, the number of source providers transmitting data to the QMRT+ will grow as well. As the pool of data collected grows, so will the usefulness of the QMRT+. For example, a larger pool of data will allow Colorado SIM to not only measure practices based on progress in comparison to their established baselines related to CQMs via Meaningful Use certified EHR technology, but will also eventually allow Colorado SIM to compare practices to others with similar characteristics.

High-quality data at the point of entry is one key to successful data reporting and sharing activities. Similar principles have been adopted by other high-performing programs such as Vermont Blueprint for Health. In order to achieve high-quality data, the following considerations are paramount:

- A focus on discrete data sets such as those that are key to SIM measure sets, which allows for measureable and focused improvement of the data; and
- Development of routine data collection and data quality feedback with data sources, which allows for proactive recognition and resolution of issues with data.

The Colorado SIM HIT strategy recognizes the importance of these concepts and, as part of the HIT plan, will accomplish the following:

- The HIT group will work with the University and Practice Transformation Workgroup to develop a data quality plan for practices related to SIM key data sets;
- Data quality components will be included in the development of the SPLIT tool;
- For practices and sources submitting data to SIM, data quality feedback processes will be established that leverage existing infrastructures such as HIE, APCD, and others; and
- Data quality checks and procedures will be incorporated into data collection and tools.

In general, data acquisition and initial aggregation will:

- Be scalable and capable of receiving more discreet data elements beyond the basic measures data from practices over time;
- Establish and incorporate processes and feedback loops that address initial and ongoing data quality issues with sources of data;
- Leverage existing infrastructure and HIE networks and previous state and federal investments in this space;

- Allow for the re-use of the data where appropriate such as HIE based longitudinal records, and other non-SIM reporting or data use cases;
- Align with other state programs related to data sharing and collection such as the Colorado Advanced Interoperability Initiative (CAII), CPCI, Testing Experience and Functional Tools (TEFT), and others; and
- Include the collection and aggregation of clinical and behavioral health information at the patient-level for use, potentially, by multiple initiatives.

The chosen vendor(s) that develop(s) data acquisition and aggregation capacity will:

- Provide technical services for capturing, acquiring, storing, and initial normalization of clinical data;
- Provide interface connections with EHRs and other data sources to acquire discreet data for multiple uses;
- Adopt and promote use of industry standards for vocabulary, content, transport, security, and measurement;
- Work with sources of data on initial and ongoing data acquisition objectives and data quality improvements;
- Coordinate the processes, people, technology, and feedback loops necessary to address missing data or data that does meet the minimum data quality standards; and
- Align with the Colorado SIM Clinical Quality Measure strategy.

The QMRT+ will serve as the SIM Central Data Hub and will aggregate and report on clinical data submitted by practices participating in the SIM program, including those participating in SIM All-Stars and practices in the transformation and advancement programs who have systems and processes that support the production of quality data for sharing. The QMRT+ will retain the capabilities developed in the initial QMRT and will greatly expand upon its data reporting and sharing capabilities. In acquiring and developing the tool, Colorado SIM, in conjunction with the chosen vendor, will:

- Accept clinical quality measurement data and aggregate clinical and behavioral health data from measure sets;
- Extend the early phase QMRT tool capabilities, providing the ability to interface with the QMRT+ to access data such as provider, payer, patient, and condition data;
- Work with data acquisition services on data quality and standard data sets and protocols;

- Support Public Health usages; and
- Allow for linkage to claims data and APCD to provide centralized clinical and cost data support.

The QMRT+ solution will include the following features and capabilities:

- A web-based interface for manual reporting that integrates with, and/or is similar to the capabilities developed in the initial QMRT;
- An electronic interface to support defined format electronic submission of practice measures that integrates with, and/or is similar to the capabilities developed in the initial QMRT;
- Secure data transport for patient level data from data acquisition organizations using standard content and transport based protocols (including CCDA and QRDA), which will leverage existing HIE infrastructure networks and others;
- Build data quality checks and processes into the solution;
- Provide data storage and normalization capabilities including MPI, provider identity, terminology, and matching services;
    - A subgroup will be formed to select or create an MPI methodology for the QMRT+ that would leverage other statewide efforts working on MPI;
- Include the ability to provide data for multiple reporting user needs;
- Build upon data collection and reporting as originally developed in the initial QMRT to include data sets available at a more granular level including provider, payer, patient, and condition data;
- Provide data extracts to other programs and applications; and
- Include the ability to provide linkages to claims data for centralized claims/clinical reporting.

Current Status and Next Steps

An RFP for the QMRT+ Central Data Hub solution will be issued in early 2016. The winning bidder will develop a solution that will offer a more robust database for quality measure data collection, and reporting capabilities and can incorporate or link with data sources beyond the original set of CQMs. Depending on the results of the RFP, this long-term solution may simply serve as an extension of the short-term solution or involve development of a new application. In either circumstance, every effort will be made to ensure minimal burden on practices as the transition from short-term QMRT to the long-term QMRT+ solution takes place.

Data sources and targets for the QMRT+ data hub will be determined in advance of the conclusion of the RFP work via the SIM All-Star practice selection process and include other practices participating in SIM practice transformation activities. Participation in practice transformation activities will prepare practices to share data.

Responses to the SIM HIT RFI published in September validated this staged approach to development and information gathered through the RFI will guide development of the long-term QMRT+ solution.

Development of a Telehealth Strategy

Colorado SIM recognizes the potential for telehealth to greatly expand access to and improve quality of integrated physical and behavioral healthcare. Telehealth services will prove particularly useful in reaching populations that face geographic barriers to accessing care, extending services to homebound individuals, and connecting primary care and behavioral health providers in settings where colocation is not feasible. The potential to expand and implement telehealth services will be strengthened due to the passage of HB 15-1029, which requires carriers to reimburse providers who deliver care through telemedicine on the same basis as care delivered in person, effective January, 2017, (for more information, see the ***Policy*** section of the HIT Plan).

Recognizing the opportunities that this legislation affords, the SIM Office will work to develop and implement a Statewide Telehealth Strategy. A planning RFP will be released to develop a recommended strategy to implement and support Telehealth adoption and utilization. Development of the strategy will involve conducting an assessment of the current state of Telehealth in Colorado as well as a gap analysis to identify key barriers to be addressed. Once the Telehealth Strategy has been identified, additional RFPs will be issued to implement the work outlined in the strategy. Where possible, the Telehealth Strategy will coordinate and build upon existing telehealth initiatives, rather than duplicate efforts. A key component of the strategy will involve the SIM-funded Broadband Expansion activities that are already underway.

Broadband Expansion

Adequate broadband capacity is crucial for providers to advance coordinated care and to take advantage of new technologies like telemedicine, health information exchanges, unified communications, and cloud services. However, many health care providers lack adequate broadband capacity to effectively leverage new technologies in ways that transform health care delivery and outcomes. Colorado SIM has entered into an agreement with CTN to expand access to broadband

services to approximately 300 underserved urban and rural healthcare facilities throughout Colorado by 2018, reaching both physical and behavioral healthcare providers. This expansion will be facilitated through the deployment of carrier broadband infrastructure that leverages the best and most cost effective-providers in each region.

CTN will provide services supporting expansion of broadband that include, but are not limited to:

- Providing administrative support and technical assistance to health care providers;
- Conducting on-site technical readiness assessments;
- Maintaining relationships with HIEs to understand and assist facilities with requirements;
- Developing processes for completing and filing required forms;
- Assessing practices for subsidy eligibility; and
- Facilitating application for Universal Service Administrative Company (USAC) administered Healthcare Connect Fund (HCF) subsidies for eligible practices.

For qualified practices, CTN will utilize USAC funds to subsidize 65 percent of the eligible services and equipment associated with these broadband expansion efforts. CTN has secured and distributed over $18 million to date for rural broadband build outs and has provided subsidized support for recurring monthly costs for connections for a large portion of the state's physical and behavioral health care providers. CTN will continue to offer support in securing these subsidies for qualified practices. In order to qualify for HCF subsidies, practices must be:

- A public or nonprofit entity;
- Classified as one of the following types of entities:
  - A post-secondary educational institution offering health care instruction, such as teaching hospitals or medical schools,
  - A community health center or health center providing health care to migrants,
  - A local health department or agency,
  - A community mental health center,
  - A not-for-profit hospital,
  - A rural health clinic, including mobile clinics, or
  - A dedicated emergency room of a rural for-profit hospital; and
- Located in an FCC-approved rural location.

Because many underserved urban health care facilities in the eight metro counties of Colorado do not meet the criteria above but still require support, SIM funds will be used to help cover the onboarding, training, and recurring monthly costs for non-USAC eligible facilities. SIM funds may be utilized to cover all allowable expected expenditures incurred in designing, constructing, and deploying the expanded broadband capabilities.

Current Status and Next Steps

CTN has completed a work plan for the course of the SIM award and has identified a list of practices to target for broadband expansion. This list includes a mix of rural and urban, system-affiliated and independently-owned, physical and behavioral health practices. While some of the 300 practices to receive broadband support may overlap with cohorts of SIM participating primary care practices, participation in either group is not contingent upon the other.

CTN is currently conducting outreach to practices and participated in a recent SIM Outreach Tour. CTN plans to connect to or expand broadband capabilities for 32 practices by January 31st, 2016. Receipt of a Funding Commitment Letter (FCL) from USAC will be used as a metric for onboarding HCF-eligible practices. The FCL is a legally binding document that ensures that sites have federally committed funds to subsidize broadband expansion as well as provides both CTN and HCPF with a high level of assurance that these sites have met all the criteria necessary to be counted toward the broadband expansion goal.

Support Data and Information Needs of other SIM Workgroups

The SIM HIT Workgroup will provide technical expertise to assist other elements of the SIM Program in achieving their goals.

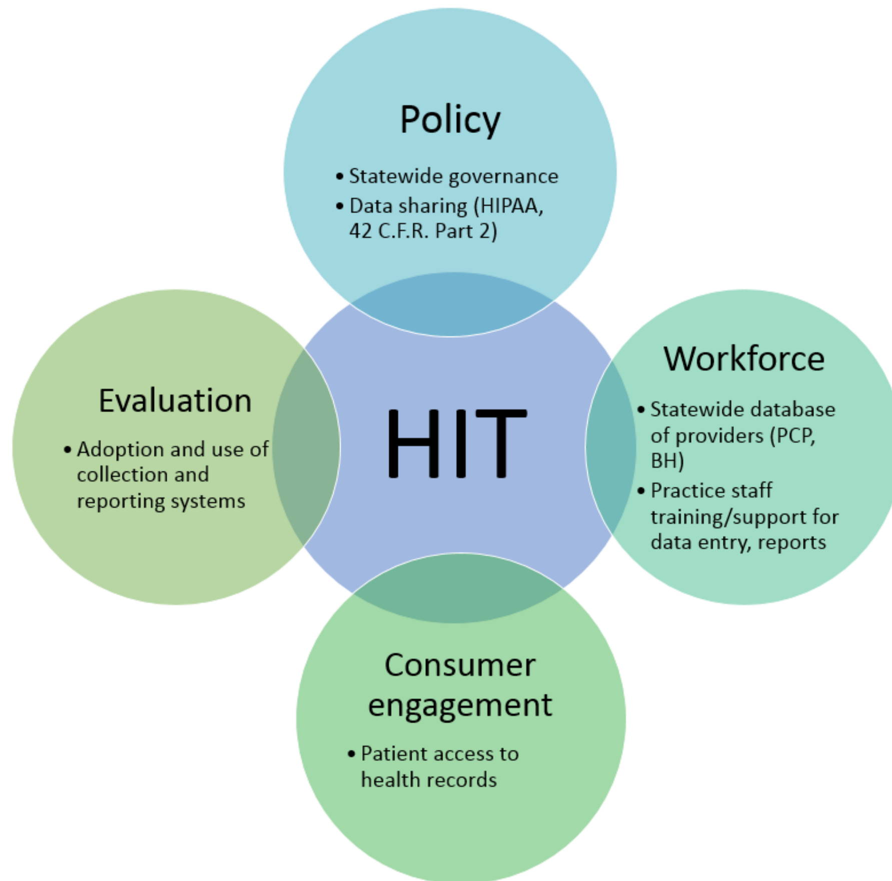
Current Status

In July 2015, the HIT Workgroup solicited the top three to five data and information needs from each of the seven other SIM Workgroups. Stated needs were incorporated into an "HIT Roadmap" for purposes of planning strategies and timelines to not only meet the SIM HIT objectives, but also to support the needs of each workgroup. As an initial task, the HIT group will offer guidance and technical assistance on the development of a Shared Practice Learning Improvement Tool (SPLIT) to support practice transformation efforts. The SPLIT will be administered by Practice Transformation Organizations (for more information see the Healthcare Service Delivery Transformation Plan) to gauge practice readiness for transformation activities and establish a baseline assessment of integration. While the Practice Transformation Workgroup and the University will develop the content of the assessment, which will

build off of readiness tools currently being used through EvidenceNow South West and other practice transformation initiatives, the HIT Workgroup will provide guidance on how to best capture this information electronically.

Future Deliverables

The HIT Workgroup will continue to engage with other SIM Workgroups on an ongoing basis, as IT cuts across multiple SIM initiatives and activities. An example of this overlap is outlined below:



The SIM Office recognizes that data sharing and communication is an important component of connecting practices to LPHAs and other community resources. LPHAs have varying capacity to communicate and share data with health systems in their communities. It is expected that the LPHAs will work with the health systems to identify the best mechanisms for data-sharing and communication. There is not any health IT requirement on local public health in order for local public health to access their funding. We will consider practices connecting to LPHAs as one criterion for All-Star status.

SIM HIT Workgroup

The SIM HIT Workgroup moved from a visionary planning group to a strategic subject matter expert group in July 2015. HIT Workgroup Members were selected with the goal of convening a set of subject-matter experts representing clinical practice, behavioral health, public health, and health information technology.

Since July 2015, the workgroup has:

- Reviewed the eCQMs from the SIM Steering Committee and incorporated them into their plans;
- Solicited the top three to five data and information needs from the other seven SIM stakeholder workgroups;
- Collaborated with the Practice Transformation Workgroup to understand their needs, build their requirements into the HIT objectives, and create the relationships that will be critical to the success of the SIM Program, particularly as the first cohort of practices is selected;
- Proactively established communication among the SIM Office Program Managers who facilitate the other Workgroups, in order to break down barriers between groups.
- Contributed to the Request for Information (RFI) for the components of the central data warehouse hub infrastructure; and
- Completed a “SIM HIT Roadmap” through a facilitated working session to fine-tune the HIT objectives, finalize definitions in order to establish a common vocabulary, and create an estimated timeline of deliverables for the next three years.

HIT-Related Policy

Many health initiatives in Colorado are currently working towards enhanced data capture and information exchange in order to improve care, reduce costs and improve health outcomes. The next steps in HIT coordination will involve maintaining the alignment of both historic strategic plans and current state health initiatives while taking into account recent technological advances and ongoing innovative community programs. Colorado SIM, in conjunction with the newly created Office of eHealth Innovation, can play a leading role in fostering continued collaboration between public and private entities.

Colorado has already taken many steps to align state policy around health care data and exchange, including the creation of the APCD, and the alignment of state law surrounding the sharing of mental

health data with HIPAA to allow organizations to share such data through the state's HIE networks, with the notable exclusion of 42 C.F.R. Part 2 data. The SIM Office will expand upon these efforts, using a variety of policy and regulatory levers as part of an ongoing strategy to advance and support SIM's HIT objectives, and ensure they are aligned with other state efforts. Specific actions that will be taken or considered include:

State and federal privacy policies, standardized consent forms, and data use agreements

Clarification of existing regulations

Conversations with stakeholders over the planning period of the model test award indicate continued confusion around of federal and state privacy policies regarding sharing behavioral health information across organizations and statewide HIE. A wide misunderstanding of regulations, particularly 42 C.F.R. Part 2, has led to differing practices surrounding the exchange of behavioral health information, with some providers and practices taking a very strict interpretation and severely limiting data exchange, while others take a more permissive stance. To address this ongoing confusion, the SIM Office intends to develop and release a White Paper and/or a one-page reference document that provides clarification around the "myths" versus the realities of behavioral health information sharing. These documents will be shared with practices participating in SIM, and potentially to a wider audience, to help develop a statewide consensus around the interpretation, and practical implementation of current privacy and confidentiality laws. The SIM Office, in conjunction with state partners, will continue to seek clarification from SAMHSA regarding 42 C.F.R. Part 2's implications for data exchange, and advocate for a revision that will allow for and support integrated care delivery models.

Standardized consent form

The SIM Office will work with COHRIO, other state HIT organizations, state agencies, and payers to develop a framework for statewide consent form for sharing behavioral health information, and support the use of statewide HIE consent models for sharing health information regardless of the care setting. In addition, SIM will provide support and assistance, as feasible, to COHRIO and other organizations to develop the technical capabilities and operational processes that will be needed to support the recommended consent model, such as the use of a secure electronic portal where consumers could submit and manage their consent to personal health information sharing.

Provider education

The SIM Office will work with stakeholder partners – including medical, nursing, and HIT programs, and state agencies – to develop education and training around privacy and confidentiality laws and consent requirements to alleviate current and future confusion surrounding these issues.

Sustainability of HIT and HIE infrastructure

As indicated in the Model Test application, HCPF is pursuing 90-10 ARRA HITECH funding through the Office of eHealth Innovation matching funds to support interoperability between state agencies and statewide HIE, and electronic health record adoption and meaningful use.

An alternative option to sustain the HIT and HIE architecture involves charging a subscription fee for entities that receive data from the central data warehouse hub, similar to the subscription model used by HIEs in Colorado. The SIM Office will work with the Office of eHealth Innovation and other stakeholders to identify the most effective and feasible solution.

Payer participation in data collection and reporting systems, support provider adoption of EHRs and connectivity with HIEs, and the central data hub;

Payer participation in health care reform is critical to measuring and achieving success. Until payers realize value and return on investment, value-based payment reform will remain a challenge. To be successful, from an HIT perspective, high quality data needs to be transmitted periodically to the established central data warehouse hub. SIM will leverage existing infrastructure components whenever possible, but may need to establish new components to meet the both the initiative's and Colorado's short and long-term goals. While it is our hope that payers will realize and act upon their need to actively participate in these processes, the SIM Office recognizes that regulatory action may need to be considered. A possible option includes promulgating regulations that require participation in data collection and reporting as part of the health plan certification process. SIM will consult with partner stakeholders and work with the Office of eHealth Innovation to determine whether such action is necessary or advisable.

Promote and facilitate the use of telehealth

Since the SIM application, legislation (HB 15-1029) was passed that removes current statutory barriers to the statewide use of telehealth in Colorado. Starting on January 1, 2017, carriers will be required to reimburse providers who deliver care through telemedicine on the same basis as care delivered in person. Furthermore, the bill prohibits carries from applying cost-sharing arrangements to services

delivered through telehealth that are not equally imposed on services delivered in person, and precludes carriers from imposing an annual or lifetime dollar maximum that applies separately to telemedicine services. While this legislation will facilitate SIM's efforts to expand the use of telehealth in conjunction with integrated care delivery, certain obstacles still remain. For example, the new legislation excludes the delivery of health care services via telephone, facsimile machine, or electronic mail systems from the definition of telehealth. SIM will advocate for the expansion of the definition of telehealth to include such communications, and identify additional barriers or obstacles that may require statutory or regulatory intervention.

Support CDPHE's efforts to connect existing public health databases to the state HIE

CDPHE's "Health Colorado: Shaping a State of Health, Colorado's Plan for Improving Public Health and the Environment 2015 – 2019" report outlines the agency's commitment to align state and local public health with health care reform efforts to increase access to and utilization of health care and related services for all Coloradans. One of identified strategies for achieving this goal involves standardizing and connecting public health data systems to allow for appropriate electronic public health and clinical data exchange through the use of Health information Exchange (HIE). Specifically, CDPHE plans to develop a standard data interoperability plan by 2016 that specifies how connections between data systems will be established and maintained to allow for appropriate electronic data exchange. By 2017, the agency will engage in real-time data sharing with Health Information Exchange, and support LPHAs in interfacing with Health Information Exchange. The SIM Office will partner with CDPHE, as appropriate, to ensure these objectives are achieved.

Dissemination of federal IT standards

The SIM Office will work with the Office of eHealth Innovation to monitor federal activity around IT standards, and disseminate any new regulations or standards to stakeholder organizations, payer, and practices. SIM will also work to ensure alignment of SIM-related HIT activities with federal standards and guidance.

Standards for HIT Tools

Colorado SIM will explore the option of requiring HIT tools used within the state to adhere to federally endorsed standards, and make recommendations regarding potential regulations.

Colorado HIT Initiatives

The table below represents an overview of statewide HIT projects at this time. The Colorado SIM Office will make every effort to coordinate with and support the work of existing initiatives. In particular, Colorado SIM regularly coordinates with the following agencies to ensure alignment of goals, interoperability of system design, and avoid duplication of efforts.

- The two HIEs within the state, CORHIO and QHN;
- CACHIE, the HIT provider for 13 of our 18 FQHCs; and
- The Center for Improving Value in Health Care (CIVHC), which administers the All Payer Claims Database.

Agency lead	Current HIT Programs	Description	Funding Source and amount

Governor's Office	**State Innovation Model**	Integrating Physical Health and Behavioral Health in primary care and mental health settings supporting the following paths to health transformation
		• Population Health Plan
		• Practice Transformation Plan
		• Technology and Measures Plan
		  ○ Telehealth expansion to support integrated physical and behavioral health
		  ○ Measure strategy supporting clinical quality measure, population health, and cost/utilization measures
		  ○ Advanced technical assistance supporting practices needing technical services (EHR adoption, HIE connections, public health reporting)
		  ○ APCD – provider level reports
		• Path to Value Based Payment Reform Plan
			Cooperative Agreement - CMMI SIM – Round 2 Test
			
			$65 million, HIT portion $13 million

	PDMP Consortium	• PDMP Consortium – reducing opioid drug abuse by improving access to PDMP through HIT integration strategy • House Bill 14-1283	N/A No appropriation Licensure fee available
	Telehealth DORA	• House Bill 15-1029 • Medical Professional Boards – telehealth policy updates and alignment	N/A No appropriation
SIM Office and HCPF (Medicaid)	**Transforming Clinical Practices Initiatives (potential funding)**	Coordinate consortium of practice transformation organizations providing practice transformation assistance to 5,000-10,000 clinical practices, administrative oversight of the TCPI Cooperative Agreement, and alignment with state and CMS health transformation programs	Grant - CMS $11 million

HCPF (Medicaid)	**HIE Maximization (FY 14-15 R-5 Budget Decision)**	Program supporting onboarding clinical practices to HIE, Build core HIE infrastructure capacity through shared services, Advancing public health reporting supporting Meaningful Use requirements and supporting other Meaningful Use objectives such as Clinical Quality Measure reporting[55] **Planned (tentative)** • Master Client Index • Master Provider Directory • Personal Health Record (PHR)	HIT/HIE APD General Fund Federal Fund approximately $40 million over 4 years $1 million General fund (GF) and $9 million Federal funds (FF)
	Personal Health Record/Consumer Engagement funding	• Community Personal Health Record (clinical data) • Build from CMS TEFT grant for long term support services grant ($1.74 million) supporting care givers and elderly, blind, disabled population	General fund HIT/HIE APD (planning)
	MMIS and BIDM	• New MMIS implementation • BIDM Clinical and non-Medicaid data interfaces with new Business Intelligence Data Management (BIDM) system	General fund MMIS APD
	Accountable Care Collaborative	Medicaid Expansion 2012 • Accountable Care Collaborative - 2012 • RCCO Rebid (2016)	
Human Services	**IT Modernization and Interoperability**	• TRAILS (SACWIS) modernization ($13.3 million General Fund) • DHS Interoperability Plan • Community Mental Health Centers • State and federal assessments capture, transport, and measurement for mental	General Fund ($2.5 million General Fund) General Fund and Eligibility APD

[55] Noted in Colorado Advanced Planning Document maintained by CORHIO, submitted by HCPF, and approved by CMS

		health and substance use assessment data(Data Integration Initiative) - building from HIE infrastructure and potentially from eCQM architecture • OBH to send encounter data to MMIS for payment • HIE integration - need granular consent management • Mental Health Institutes electronic health record (EHR) implementation	General Fund Federal block grants MMIS Grant, HIE APD General Fund
HCPF (CORHIO and QHN)	**ONC Advanced Interoperability of Health IT (potential funding)**	Grant advancing secure information sharing among medical settings including long-term care, behavioral health, ambulatory in preparation for widespread information sharing to improve health and reduce costs. • Ambulatory providers - encounter summary • Behavioral health providers -demonstration projects for consent management • LTPAC MDS & OASIS to CCD	Grant - ONC HITECH $2.74 million
State	**State agency HIT integration**	Multiple agencies received funding supporting health IT platform adoption and integration with the HIE. Statewide information sharing with no duplication of interfaces to state systems.	General Funds Approximate state funding $6-12 million
Corrections	**EHR**	• DOC Electronic Health Record • DOC - EHR implementation, Meaningful Use attestation assessment, "suspend" function (advising)	General Funds Approx. $16 million
CIVHC	**All Payers Claims Database**	2011 statute, Executive rule for self-funded insurers to submit by end of year. • Claims data aggregation and reporting	Subscription $500k annually Medicaid scholarships
CORHIO	**Health Information Exchange**	• Results Delivery • Direct (secure email) • Longitudinal Health Record • Single Sign On • Public Health Reporting • ADT/alerting	Subscription State HIE Cooperative Agreement LTPAC Challenge Grant REC grant

		Professional Services • Regional Extension Center • Transformation Support Services **Planning** • Integration with DOC	ONC Advanced Interoperability TCHF funding
QHN	**Health Information Exchange**	• Results Delivery • Direct (secure email) • Longitudinal Health Record • Single Sign On • Crimson Care Registry/Management • ADT alerting **Professional Services** • Regional Extension Center partner • RMHP Quality Improvement support	Subscription Beacon grant ONC Advanced Interoperability TCHF funding
HCPF Payer Collaborative	**Comprehensive Primary Care Initiative**	**Payer Collaborative -** • Multi-payer consortium	
CDPHE	**LPHA EHR**	leveraging MHI Cerner platform and direct reporting to CDPHE registries	
	Clinical Information Strategy	Meaningful use measures collection through Immunization Registry, Electronic Lab Reporting and Cancer reporting	
C4HC	**State based insurance exchange**	Colorado Benefit Management System, Share Eligibility System, and Connect for Health Colorado - Technical integration supporting Medicaid and exchange eligibility through a shared system	

Component Summary Table

SIM Component/Project Area: *Health Information Technology*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Telehealth	• Support expansion of broadband statewide • RFP for telehealth strategy vendor • Development of statewide telehealth strategy • Implement telehealth strategy	Colorado Telehealth Network	HIT	Expand broadband to 300 sites
Shared Practice Learning and Improvement Tool (SPLIT)	• Design recommendations on SPLIT • Training for Practice Transformation Organizations on use of SPLIT • Initial use of SPLIT with first cohort primary care practices • Ongoing enhancements to SPLIT	University of Colorado to subcontract with a to-be-determined vendor	HIT	Number of SIM-participating practices using SPLIT (via Practice Transformation Organizations)
Quality Measurement Tool (QMRT) Development	• Selection of vendor for design of short-term QMRT • Development of benchmark report for First Cohort Practices • Quarterly collection of Clinical Quality Measures via QMRT	To-be-determined Vendor	HIT	Quality Measure Tool Operational; Number of SIM practices submitting quarterly reports via QMRT
SIM All-Stars	• Identification of qualifying characteristics of "All-Star" sites • Identification of resources provided to All-Stars. • Selection of Cohort #1 All-Star Practices • Selection of Cohort #2 All-Star Practices • Selection of Cohort #3 All-Star Practices • Development of All-Star case studies • All-Stars honored and publicized	To-be-determined Vendor	HIT	Establishment of All-Star incentives; number of SIM All-Stars selected; number of case studies developed; number of All-Stars honored
Data Acquisition and Aggregation with QMRT+ (Central Data Hub)	• Infrastructure design recommendation • RFP to select vendor responsible for development of QMRT+ • Completion of QMRT+ • Quarterly data collection via QMRT+	To-be-determined Vendor	HIT	Number of SIM-participating practices reporting via QMRT+

Program Monitoring and Reporting

Colorado SIM is contracting with an evaluation vendor to perform evaluation and continuous improvement monitoring of the SIM project. The RFP to select the evaluation vendor was released in September. The vendor will be selected in January and have a contract in place by February. The overarching aim of the evaluation is to assess Colorado SIM progress in achieving the overall project goal of increasing access to comprehensive primary care, including integrated behavioral health, that improves the population's health and experiences with care while containing, if not lowering, costs through value-based payment models for integrated primary care.

The evaluation vendor will utilize a mixed-methods approach in order to examine the overall impact of Colorado SIM, the effectiveness of policy and regulatory levers, and to determine which program characteristics, implementation approaches or adaptations, and contextual factors are associated with better outcomes and reductions in costs. The evaluation vendor will assist Colorado SIM in identifying which integration and payment models have the most promise for improving care, improving health, and lowering costs in different settings and geographic locations. As participating practices move along a continuum toward fully integrated care, the evaluation vendor will help the SIM Office understand barriers to implementation, success factors, and areas for improvement. The contractor will estimate the impact of SIM efforts under various conditions and for multiple sub-groups, including urban and rural environments, bidirectional integration, and practice type, size, and maturity. The evaluation strategy will also assess the sustainability of the model to inform work beyond the project period.

The evaluation vendor will develop and execute a self-monitoring and evaluation plan that incorporates a formative/process component, an outcome/impact component with a return on investment (ROI) analysis, and a rapid-cycle component that will inform ongoing model adjustments.

Self-Monitoring

The contractor will work in collaboration with state agencies to develop and implement the program's self-monitoring efforts. The goal of this collaboration is to establish the capability and infrastructure to enable the state to sustain rigorous outcome measure-driven program monitoring beyond the period of the cooperative agreement.

Formative/Process Evaluation

The formative component will evaluate reach among different groups, including consumers, providers, and payers. It will provide critical contextual information on the adoption, implementation, and maintenance of SIM components, including payment reform, primary care and behavioral health practice integration, community-level population health efforts, and the development of HIT infrastructure. It will encompass evaluation of major process components such as stakeholder engagement, workforce, and policy efforts. It will also encompass administrative costs to practices related to integrating care.

The evaluation vendor will collect data to inform the formative component through site visits, focus groups, and key informant interviews with stakeholders. The evaluation vendor will collect additional information from model documents, including practice transformation facilitator notes and CDPHE reports on population health efforts. These qualitative methods will aid in understanding how the model was implemented in practices and communities; what worked and what did not; explain what may have contributed to variation in reach, effectiveness, and maintenance; and describe stakeholder engagement. The SIM Office, in collaboration with CDPHE, has successfully added 10 questions to the Behavioral Risk Factor Surveillance System (BRFSS) population health survey on access to behavioral health services for estimates of reach statewide and for county-based regions. Additional process measures assessing the implementation of SIM components including practice transformation, payment reform, population health improvement, HIT, policy, workforce development, stakeholder engagement and sustainability will be identified in conjunction with the selected evaluation vendor.

Impact/Outcome Evaluation

The impact evaluation component shall use a prospective, quasi-experimental design that relies on the phased roll-out of practices to provide in-state comparison groups for difference-in-difference and interrupted time series designs to help control for as many confounding factors as possible. The evaluation vendor will track and report on outcomes measures identified to date include the following clinical quality, cost of care, utilization, population health, and access to care measures. Additional measures related to health outcomes/quality, population health outcomes, delivery systems transformation, care and, consumer experience will be identified in conjunction with the selected evaluation vendor.

The selected evaluation vendor will utilize various methods to assess the level of integration among participating practices. These include tracking progress toward the 10 practice milestones included in the practice transformation RFA, Bodenheimer's building blocks, and the SAMHSA-HRSA Integrated Practice Assessment Tool (IPAT). Additionally, as part of the bi-directional efforts, CMHCs will be identifying instruments to measure quality of life to administer with consumers.

The evaluation of cost of care and utilization will be a coordinated effort that combines the evaluation vendor's measurement of the administrative cost of implementation and Milliman's work on health care costs and utilization to examine the business case and sustainability of the model. The evaluation vendor will coordinate this piece of its work with Milliman who will analyze claims and conduct the Return on Investment (ROI) analysis.

Rapid-Cycle Improvement

The rapid-cycle component will utilize continuous quality improvement and apply the concepts of community-based participatory research to inform real-time and actionable decisions about changes to model implementation and ultimately inform best practices. The evaluation vendor's responsibility for the rapid-cycle component is at the program level rather than the practice level. The evaluation vendor will coordinate with the University of Colorado (which will

have responsibility for supporting practices in carrying out their own practice-level rapid cycle work) and provide the data necessary to provide the technical assistance needed by the practices to conduct their quality improvement activities.

Evaluation Questions

The evaluation will enhance the SIM Office's understanding of the impact of various interventions within the SIM model. These components, high-level evaluation questions and potential data sources are included in the table below. Evaluation questions, measures and data sources will be finalized in conjunction with the selected evaluation vendor, CMMI federal evaluator, and stakeholders.

SIM Component	Evaluation questions	Potential data sources
Practice transformation	What proportion of practices provided integrated care? To what extent did practices move along the continuum of integration? What steps did practices take to assess and continually improve delivery of integrated care via process redesign, culture change, and IT?	Key Informant Interviews (KIIs) with practices; technical assistance records from Practice Transformation Organizations
	What was the level of access to care for integrated primary care and behavioral health services?	Claims; provider and consumer surveys
	To what extent are consumers satisfied with the experience of primary and behavioral health care?	TBD
	Among SIM-participating primary care practices, which of the 18 CQMs improved over time?	Claims; practice reported
Payment reform	What proportion of primary care and behavioral health practices and beneficiaries participated in SIM alternative payment models? Do alternative payment models result in lower health care costs?	Claims data from payers on alternative payment models
	What was the total cost of care for consumers attributed to SIM participating practices?	Claims

	To what extent did the utilization of services differ for consumers attributed to SIM participating practices?	Claims
Improving population health	What is the reach of LPHAs and population health collaboratives in implementing behavioral health and wellness initiatives?	CDPHE; KIIs
	To what extent do the 12 population health measures change over time?	Existing population health surveys; CDPHE
HIT	To what extent has data been integrated across primary care and behavioral health practices? What is the reach of telehealth on the delivery of primary & behavioral health care?	KIIs; provider surveys; information from HIT vendor on practices participating in telehealth models
Workforce Development	To what extent have identified gaps in the licensed and lay health workforce been addressed?	Workforce Workgroup report
Stakeholder Engagement	How satisfied were stakeholders with their level of participation in the planning and implementation of SIM? To what extent were stakeholders across the state engaged in CO SIM?	Stakeholder survey
Policy	To what extent did SIM develop policy recommendations and engage with state agencies, including but not limited to CDHCPF, CDHS, CDPHE, DORA, and DOI, to create specific changes to established policies or regulations regarding the delivery of integrated services?	Policy Workgroup tracking; KIIs
Sustainability	What alternative payment models are compatible with the additional administrative and practice costs associated with operating integrated care delivery models to sustain these care delivery models after the SIM test period? What factors contribute to sustainability?	Practice cost data collection (compared to analysis of payment models); KIIs

The evaluation vendor will work with the federal CMMI evaluator, SIM Office, SIM Evaluation Workgroup, and other key stakeholders to develop the evaluation framework and logic model, methodology and data analysis plan, evaluation measures, and baseline calculations. While the CQMs have already been submitted to CMS and approved, most measures are still being discussed within the workgroups and will be selected, refined, and finalized in conjunction with the evaluation vendor.

Existing data sources will be utilized, including APCD and population health surveys. The evaluation vendor will also leverage practice transformation technical assistance records and data on the CQMs submitted by participating

practices. The evaluation vendor will request information from participating partners, including but not limited to information from payers on alternative payment models, information from the HIT vendors on telehealth and data aggregation, and information from CDPHE on the population health plan implementation. The evaluation vendor will also be responsible for primary data collection, including site visits, key informant interviews, and focus groups with participating practices and consumers, as well as state and local government agencies, tribal communities, consumer advocacy groups, and public health organizations.

The evaluator will submit quarterly reports to the SIM Office and CMMI, including information on reach, effectiveness, and maintenance of model components and non-financial outcomes measures. Milliman will be responsible for reporting on healthcare costs and utilization, including cost saving and ROI.

Component Summary Table

Respondents to the evaluation RFP will submit proposals for deliverable-based payments. Total budget for the first year of evaluation through January 31, 2017 will not exceed $1,227,600. Total budget for the second year of evaluation February 1, 2017 through January 31, 2018 will not exceed $1,050,000. Total budget for the third year of evaluation February 1, 2018 through January 31, 2019 will not exceed $800,000. Total budget for final deliverables submitted post-implementation February 1, 2019 through March 31, 2019 will not exceed $450,000. Once the contract is finalized, Colorado SIM will identify the budget allotted to each specific deliverable. For the purpose of the RFP, the SIM Office provided guidance for the percentage of yearly funds to be used for different "phases" or groups of deliverables. The proposed schedule of deliverables and percentage of allotted budget is in the table below. Primary drivers are left off of this component table, as evaluation is driven by and informs all components of SIM. The vendor column is also left off of this component table, as all activities will be included as deliverables in the selected evaluation vendor's contract.

Activities/milestone achievements	Metric (proposed deadline)	Anticipated % of expenditures
Evaluation Year 1 (evaluation contract effective date – January 31, 2017)		***$1,227,600 total***
Year 1 Phase 1		
Initial Work Plan	30 days following the effective date and updated as needed ~ Feb 28, 2016	**50%**
Revised Evaluation Framework	45 days following the effective date ~ Mar 15, 2016	
Revised Logic Model	45 days following the effective date ~ Mar 15, 2016	

Revised Methodology	60 days following the effective date ~ Mar 31, 2016	
Annual Data Analysis Plan	75 days following the effective date ~ Apr 15, 2016	
Year 1 Phase 2		
Central Repository of Measures	60 days following the effective date and updated as needed ~ Mar 31, 2016	**25%**
Plan for Capturing Baseline Data	60 days following the effective date ~ Mar 31, 2016	
Establishment of Baseline	90 days following the effective date and updated as needed ~ Apr 30, 2016	
Year 1 Phase 3		
Quarterly Report (Feb – Apr 2016)	15 days following each project quarter – May 15, 2016	**25%**
Quarterly Report (May – Jul 2016)	15 days following each project quarter – Aug 15, 2016	
Quarterly Report (Aug – Oct 2016)	15 days following each project quarter – Nov 15, 2016	
Evaluation Year 2 (February 1, 2017 – January 31, 2018)		***$1,050,000 total***
Year 2 Phase 1		
Preliminary Annual Report (Feb 2016 – Jan 2017)	30 days following Year 1 implementation – Feb 28, 2017	**40%**
Annual Data Analysis Plan	30 days following Year 1 implementation– Feb 28, 2017	
Final Annual Report (Feb 2016 – Jan 2017)	60 days following Year 1 implementation – Mar 31, 2017	
Year 2 Phase 2		
Draft Sustainability Plan	60 days following year 1 implementation – Mar 31, 2017	**25%**
Year 2 Phase 3		
Quarterly Report (Feb – Apr 2017)	15 days following each project quarter – May 15, 2017	**35%**
Quarterly Report (May – Jul 2017)	15 days following each project quarter – Aug 15, 2017	

Quarterly Report (Aug – Oct 2017)	15 days following each project quarter – Nov 15, 2017	
Evaluation Year 3 (February 1, 2018 – January 31, 2019)		***$800,000 total***
Year 3 Phase 1		
Preliminary Annual Report (Feb 2017 – Jan 2018)	30 days following Year 2 implementation – Feb 28, 2018	**60%**
Annual Data Analysis Plan (Feb 2018 – Jan 2019)	30 days following Year 2 implementation– Feb 28, 2018	
Final Annual Report (Feb 2017 – Jan 2018)	60 days following Year 2 implementation – Mar 31, 2018	
Year 3 Phase 2		
Quarterly report (Feb – Apr 2018)	15 days following each project quarter – May 15, 2018	**40%**
Quarterly report (May – Jul 2018)	15 days following each project quarter – Aug 15, 2018	
Quarterly report (Aug – Oct 2018)	15 days following each project quarter – Nov 15, 2018	
Evaluation Post-implementation (February 1, 2019 – March 31, 2019)		***$450,000 total***
Post-implementation Phase 1		
Preliminary annual report (Feb 2018 – Jan 2019)	30 days following year 3 implementation – Feb 28, 2019	**100%**
Final sustainability plan	30 days following year 3 implementation – Feb 28, 2019	
Final annual report (Feb 2018 – Jan 2019)	60 days following year 3 implementation – Mar 31, 2019	

Data Collection, Sharing and Evaluation

Colorado SIM will cooperate with CMS to provide data and facilitate efforts at the state-level necessary to conduct the federal evaluation. Colorado SIM is contracting with a state-level evaluation vendor to perform an evaluation and continuous improvement monitoring of the SIM project. The RFP to select the evaluation vendor was released in September. The vendor will be selected in January and have a contract in place in February. The evaluation vendor is responsible for data collection, storage, cleaning, and creation of analytic datasets, continuous quality improvement,

and analysis of evaluation metrics on a quarterly basis. The evaluation vendor will be responsible for storing, managing, and securing these data in accordance with Department and CMS rules and regulations. The evaluation vendor will work directly with RTI as the federal evaluator to supply necessary data. Within the first few weeks of the contract, the selected evaluation vendor will propose a schedule for meeting regularly with RTI to coordinate federal and state level evaluation efforts. The state evaluation vendor will coordinate and facilitate any sampling and data collection on behalf of CMS. The evaluation vendor will cooperate with RTI for primary data collection efforts such as surveys, focus groups, key informant interviews, and any other requirements for the federal evaluation. The SIM Office will ensure that the necessary legal mechanisms and agreements are in place to ensure timely delivery of data to CMS and RTI.

The primary source of data for the quantitative analysis component of the evaluation will be Colorado's APCD administered by CIVHC. Colorado SIM has put into place data sharing mechanisms with CIVHC to access APCD data on a regular basis. Within the terms of CIVHC's contract with the SIM Office, an APCD data stream will be sent to Milliman, the selected evaluation vendor, and the selected HIT data aggregation vendor on a quarterly basis. CIVHC is committed to providing CMS and the federal evaluator with data as requested in a manner that is conducive to conducing the federal evaluation. Once data specifications are identified, CIVHC will work with RTI to start the data request process. HCPF rules require that a multi-stakeholder Data Release Review Committee (DRRC) review data requests and advise the Administrator whether such requests meet the criteria for fulfillment. This process can take up to 30 days with an additional 30 days for data processing once approved, though CIVHC will work with partners to expedite requests as much as possible. CIVHC will work with the DRRC to ensure SIM requests are addressed in a timely way and that any potential concerns are addressed before the application goes before the DRRC to avoid delays. If the request is identical from one quarter to the next, there is no need to complete the application and approval process; the dataset will be pulled and delivered automatically. Any changes to the quarterly requests will require a resubmission to the data release review committee prior to pulling the data.

CIVHC will be able provide data related to beneficiaries impacted by SIM, across participating payers. CIVHC will work with the selected evaluation vendor and Milliman to develop a plan for establishing baseline and providing historical data to the extent it is available within the APCD. Obligations under HIPPA and HITECH require CIVHC to narrowly tailor all requests to minimize the Protected Health Information (PHI) released. The SIM Office is working with payers and Milliman to determine an attribution methodology for SIM. CIVHC can run the attribution for participating practices and beneficiaries, de-identify the data, and share with Milliman and the state and federal evaluators as data sets for each practice, in addition to the statewide data sets. This minimizes the distribution of sensitive data and complies with federal reporting requirements. Providing the PHI necessary to conduct the federal evaluation is within the scope of CIVHC's contract with the SIM Office. CMS and RTI will follow the standard data release procedures and submit a formal request for PHI as needed. CIVHC will work with the SIM Office to create an identifier for beneficiaries impacted by SIM. As the Master Person Index is developed, the SIM Office will work to align efforts and determine the most appropriate identifier for reporting purposes.

CIVHC can provide beneficiary contact information to the extent it is necessary and will comply as fully as regulations and laws allow. As with all requests for PHI, the request must be tailored to requirements under HIPAA and HITECH. The selected state evaluation vendor will work with RTI to determine the beneficiary contact information necessary for federal evaluation purposes and assist in the data request process. The state evaluation vendor will facilitate sampling of beneficiaries for RTI key informant interviews, focus groups, or surveys. The SIM Office anticipates clarification from RTI regarding the specific purpose and data elements requested related to beneficiary contact information and will put the mechanisms in place to share data according to state and federal regulations. The state evaluation vendor will support RTI in identifying beneficiaries and strategies that may include obtaining consent for participating in the evaluation prior to providing contact information.

RiseHealth provides an additional data source for Colorado SIM. RiseHealth administers Stratus, a multi-payer data-sharing online tool which is financed by Colorado payers and currently utilized by practices participating in CPCI to access practice-level claims data. Payers have agreed to allow 76 unused RiseHealth licenses to be used for SIM practices. The SIM Office is exploring strategies for providing all practices participating in the practice transformation cohort with licenses to directly access practice-level claims data via the Stratus tool. The SIM Office is also exploring opportunities to provide Milliman and/or the state-level evaluator with RiseHealth licenses to obtain data related to participation in alternative payment models and potentially model performance metrics to supplement APCD data.

Practices will also submit data related to clinical quality measures directly to a data aggregation tool developed by SIM HIT efforts. In the short-term, practices will submit aggregate numerators and denominators for the clinical quality measures within the QMRT solution. In addition to being shared back to practices on a quarterly basis as part of rapid cycle improvement for practice transformation efforts, this aggregate-level reporting can be shared with state evaluator, CMS and RTI on a quarterly basis. Once the long-term QMRT+ data aggregation solution is in place, which includes both individual and aggregate level reporting, Colorado SIM will work with CMS to put the necessary mechanisms in place for sharing data with CMS and RTI. As some clinical quality measure data will eventually be pulled directly from the HIE, a legal review will be conducted to determine the data sharing mechanisms needed to populate QMRT+. Please see the ***HIT*** section of the Operational Plan for more information regarding the QMRT data aggregation solution. In addition to the practice-reported clinical quality measures, practice assessment and readiness data will be collected at the practice level via the SPLIT tool. The selected evaluation vendor will work with Practice Transformation Organizations to utilize SPLIT data for setting practice-level baseline and tracking over time for rapid cycle improvements. Aggregate and/or de-identified data related to practice assessment and readiness will be shared with CMS and RTI. Please see the ***HIT*** section of the Operational Plan for more information regarding the SPLIT tool.

Assuming full compliance with HIPAA and other state and federal privacy law, the only firm barrier to disclosure of data relevant to SIM is federal law (42 C.F.R. Part 2). 42 C.F.R. Part 2 prohibits release of substance use data, employing a more stringent standard than HIPAA. As this federal regulation is currently under review, a number of Colorado organizations submitted comments during the public comment period requesting a change to 42 C.F.R. to allow sharing

of behavioral health information for integration of mental and physical health in the RCCOs for the ACC. Such a change would also apply to SIM, for integration of physical and behavioral health care. Once the referenced rule is passed, it would provide a safe harbor authorizing the data requested under the grant. Currently, CIVHC does not receive substance use information covered by the regulation and cannot report on that information absent a change to federal regulation and an opportunity to begin collecting and aggregating such data.

Colorado SIM is exploring strategies for obtaining client consent for sharing substance use data. Colorado has successfully operationalized client authorizations for its Medicaid program – obtaining a 97 percent success rate in gaining client written consent to allow for care coordination and data exchange in the ACC program. Additionally, HCPF was awarded the ONC Advanced Interoperability grant this summer where the two HIEs (CORHIO & QHN) will each pilot a separate solution for consent for sharing substance use data. The grant ends in June 2017 and the goal is to see if one or both of the piloted solutions would work for Colorado. As a future function of the HIEs, this solution would apply to Colorado SIM. Obtaining client consent would allow substance use data to be reported within the long-term QMRT+ data aggregation tool. CIVHC has also developed a set of claims-based proxies for the identified clinical quality measures, including measures related to behavioral health. Per the ***HIT*** section of the Operational Plan (HIT-Related Policy sub-section), the SIM Policy and HIT Workgroups will work on strategies to address 42 C.F.R. Part 2. Pending any changes to the rule, Colorado SIM will put the necessary mechanisms in place to share substance use data with CMS and RTI, as federal and state regulations allow.

If it becomes necessary to pull claims data directly from the Department's MMIS, the SIM Office will work with CDHCPF, CMS, and RTI to understand the data elements requested and put the legal mechanisms in place to share the data for federal evaluation. The selected state evaluation vendor will also coordinate data collection among various SIM vendors and stakeholders, including Practice Transformation facilitation notes, CDPHE reports on the reach of population health efforts and population health survey data, and HIT vendor reports on telehealth expansion.

The SIM Office agrees not to receive additional reimbursement for providing data or other reasonable information to CMS or another government entity or contractor.

Component Summary Table

See Component Summary Table in the ***Program Monitoring and Reporting*** section of the Operational Plan.

Fraud and Abuse Prevention, Detection, and Correction

Colorado currently has a robust set of statutes, programs, and processes in place to prevent, detect, and correct health insurance fraud and abuse. The Colorado SIM Office anticipates that payment reform and other activities undertaken as part of the initiative will fit within the current statutory and regulatory mechanisms outlined below.

Medicaid

State Statute

The State of Colorado has adopted a Medicaid anti-fraud statute to prevent the submission of false and fraudulent claims to the Colorado Medicaid program.[56] The Colorado Medicaid False Claims Act (CMFCA), enacted in 2010, makes it unlawful for any person to knowingly present a false claim to Medicaid, make a false representation of a material fact in connection with a claim; present a cost document the person knows contains a false material statement; or make a claim for services payable by Medicaid with knowledge that the individual who furnished the services was not licensed to provide such services. Person(s) who violate state statute are subject to civil penalties of not less than five thousand five hundred dollars ($5,500) and not more than $11,000, plus three times the amount of damages that the state sustains because of the act of that person.

Colorado Health Care Divisions

Colorado Department of Health Care Policy and Financing

CDHCPF has multiple programs and resources in place to combat fraud, waste, and abuse. The Department's Program Integrity Section is primarily charged with detecting and deterring fraud, waste, and abuse in the Colorado Medical Assistance program, monitors Medicaid providers for compliance with Medicaid statutes and rules to recover inappropriate payments. A staff of nurse reviewers, claims reviewers, and data analysts conducts compliance monitoring, which involves reviewing a provider's paid claim and comparing it to that of their peers in order to identify those who are significantly above the norm. Compliance monitoring also includes educating the employees of providers about false claims.

The Program Integrity section also conducts preliminary investigations of suspected fraud, a process that involves extensive claims review and some medical records review. If the suspicion seems warranted, the matter is either assigned to an internal post-payment claims review for audit, or referred to the Colorado Medicaid Fraud Control Unit, housed within the State of Colorado Attorney General's office, for a formal investigation and/or prosecution.

Several other sections within CDHCPF are also engaged in fraud prevention and detection:

- Benefits Coordination Section – Works to recover money and avoid unnecessary costs, and ensures that Medicaid is the payer of last resort when clients have other insurance, per federal regulations;
- Nursing Facility Section – Works to detect and reduce fraud, waste, and abuse associated with Medicaid Nursing Facilities in Colorado;
- Compliance Section – Works to reduce fraud, waste, and abuse committed by recipients of CDHCPF programs; and

[56] Colo. Rev. Stat. §§ 25.5-4-304 and 305 and 306; Colo. Rev. Stat. § 13-80-101; Colo. Rev. Stat. § 24-50.3-103

- Client Over-Utilization Program (COUP) – Also known as "Lock-In," COUP is a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of care or services. The program uses a post-payment review process to identify excessive patterns of utilization in order to rectify over-utilization practices of clients. Potential COUP client's usage is reviewed on a quarterly basis. Medicaid clients whose utilization of benefits without medical necessity have exceeded certain program parameters (i.e., use of 16 or more prescriptions, use of three or more pharmacies, excessive ER and physician visits) in a three month period may be restricted to one designated pharmacy and one primary care physician when there is documented evidence of abuse or over-utilization of allowable medical benefits.

In addition to staff efforts, CDHCPF has a Diagnosis Review Contract in place, and is working to execute a Recovery Audit Contract. Earlier this year, HCFP sought and received an extension to an existing exception from Medicaid recovery contract audit requirements, as the agency has been unable to secure any bids on the contract during the re-procurement process. Colorado will continue to consult with CMS and seek other interim solutions for conducting post-payment compliance reviews and audits.

Finally, CDHCPF participates in Payment Error Rate Measurement (PERM) program, developed by CMS to comply with the Improper Payments Information Act (IPIA) of 2002[57] (amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA[58]). PERM measures improper payments in Medicaid and CHIP and produces error rates for each program, based on reviews of the FFS, managed care, and eligibility components of Medicaid and CHIP in the fiscal year (FY) under review.

Colorado's next PERM review of provider payments is scheduled to occur between the summer of 2015 and the summer of 2017. The 2016 PERM cycle will review provider payments during the federal fiscal year 2016 (October 2015 – September 2016). Due to the "newness" of the ACA, CDHCPF is currently conducting eligibility review pilots with guidance from the federal government, which do not necessarily coincide with the usual PERM cycle.

Colorado Medicaid Fraud Unit - State of Colorado Office of the Attorney General

The Colorado Medicaid Fraud Control Unit (MFCU), housed within the Attorney General's Office, is tasked with investigating and prosecuting cases of Medicaid provider fraud. MFCU's mission is to protect state and federal funds from fraud against Medicaid by individuals or companies who provide services and to protect residents of long-term care facilities from physical or threatened abuse, mental or emotional abuse, sexual abuse, criminal neglect, and financial abuse.

The MFCU employs a professional staff of criminal investigators, an auditor, a nurse investigator, and prosecutors experienced in criminal and financial investigations. The MFCU's abuse jurisdiction extends to all personal care boarding homes, adult day care facilities, hospitals, skilled nursing centers, rehabilitation centers, long-term facilities, and some

[57] Public Law 107-300
[58] Public Law 111-204

assisted living centers – regardless of whether the patient is a Medicaid recipient or not; the Unit does not investigate abuse in the home or in non-Medicaid facilities. MFCU fraud jurisdiction covers all Medicaid providers.

The MFCU has authority to hold individuals or entities accountable through criminal prosecution and/or civil litigation. The Unit also makes recommendations to the U.S. Department of Health and Human Services, Office of the Inspector General to exclude individuals or entities from participating in federally funded programs.

Colorado Department of Human Services, CDHS

While the MFCU investigates and prosecutes cases of provider and facility fraud, CDHS has authority over individuals who receive services as part of the Medicaid Program. CDHS's county offices investigate suspected cases of recipient fraud, and the local District Attorney's Office prosecutes those individuals who practice fraudulent schemes.

CDHS's jurisdiction also encompasses inappropriate or fraudulent activity by CDHS employees, CDHS management, CDHS appointees, and community partners, including contractors, grantees, vendors, and other sub-recipients. The Department has authority to examine all relevant records, financial statements, and client information and to conduct interview of those involved to complete investigations.

Commercial Insurance

State Statute

Colorado state law requires any licensed insurance company doing business in the state to "prepare, implement, and maintain an insurance anti-fraud plan."[59] The anti-fraud plan, which is required to be submitted annually to the Colorado DOI, must outline the company's specific procedures to:

> "(I) Prevent, detect, and investigate all forms of insurance fraud, including fraud by the insurance company's employees and agents, fraud resulting from false representations or omissions of material fact in the application for insurance, renewal documents, or rating of insurance policies, claims fraud, and security of the insurance company's data processing systems;
> (II) Educate appropriate employees about fraud detection and the company's anti-fraud plan;
> (III) Provide for the hiring of or contracting for one or more fraud investigators;
> (IV) Report suspected or actual insurance fraud to the appropriate law enforcement and regulatory entities in the investigation and prosecution of insurance fraud."

Additionally, insurance companies are required to include an anti-fraud statement on all insurance applications, policies, or claim forms, language substantially similar to:

> "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include

[59] CRS 10-1-128

imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

Colorado Division of Insurance – Department of Regulatory Affairs

The Colorado DOI is authorized to conduct market examinations of commercial insurance carriers in the state in accordance with Colorado statues and regulations.[60] Colorado was one of seven states that adopted the National Association of Insurance Commissioner's "Market Conduct Surveillance Model Law," and large sections of the model have been incorporated into state statute. Market conduct examiners, when possible, use the NAIC Market Regulation Handbook and follow NAIC guidance when conducting exams.

Company anti-fraud plans are regularly reviewed as part of market conduct exams, to ensure compliance with state laws. Exams may also investigate fraud allegations, either against companies for committing fraudulent activities, or against consumers accused of committing fraud against a company. The Attorney General has jurisdiction to prosecute insurance fraud throughout the state of Colorado.

Guarding Against New Fraud and Abuse Exposures

As previously noted, the SIM Office will rely on current statutory and regulatory mechanisms to protect against fraud and abuse exposures that may occur in relation to payment reform activities. As an additional safeguard, the SIM Office will include a clause, similar to the following, in the contracts with all practices participating in the initiative:

Each participant must comply with all applicable Colorado and federal laws and regulations; such compliance includes but shall not be limited to, compliance with all applicable federal laws and regulations designed to prevent fraud, waste, and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et seq), and the anti-kickback statute (42 U.S.C. section 1320a-7b(b)).

Colorado SIM will also ensure that payers participating in the model are in compliance with state and federal anti-trust laws. All payers participating in SIM payment reform models are part of the self-funded and self-governing Colorado MPC. All meetings of the MPC begin with a reading of, and agreement to, the following anti-trust statement:

"Payers participating in the Colorado Payer Collaborative agree that all activities are in compliance with federal and state antitrust laws. In the course of discussion, no financial information from participating payers will be shared with other payers or the general public. During meetings and other activities, including all formal and informal discussions, each

[60] CRS 10-1-210 to 10-1-213

participant will refrain from discussing or exchanging information regarding any competitively sensitive topics. Such information includes, but is not limited to:

- PMPM
- Shared savings
- Information about market share, profits, margins, costs, reimbursement levels, or methodologies for reimbursing providers, or terms of coverage."

Plan for Existing Fraud and Abuse Protections that may Pose Barriers

The SIM Office has not identified any existing fraud or abuse protections that would prevent the implementation of Colorado's model. Colorado SIM will work with payers, practices and providers, to ensure they are in compliance with state and federal fraud, anti-trust, anti-kickback, and self-referral laws.

The scope of Colorado's SIM initiative focuses first on enhancing primary care and does not explicitly address the role of specialty or hospital-based care because systems based on primary care are best positioned to improve overall health and control costs. Specialty care, including care for those with severe mental illness and significant substance abuse issues, will continue to be referred to specialists outside primary care. In addition, our proposed payment reform models will not hold providers accountable for costs incurred outside the walls of the primary care practice. As Colorado's health care delivery system moves toward more coordinated systems of care and ACOs, it will become more feasible to transition providers into outcome-based payment arrangements that reflect the total cost of care across the patient care spectrum. Once Colorado SIM has successfully integrated behavioral health into a primary care setting and has moved to value-based payment for primary care, it will have the basic infrastructure to begin creating larger coordinated systems of care. These systems of care will include the full spectrum of care including bidirectional physical and behavioral health integration, public health, oral health, and long-term services and supports.

The SIM Office recognizes that the introduction of new payment models will present opportunities not only for improved care and cost savings, but also for new forms of fraud and abuse. The ongoing evaluation of SIM's payment reform activities will serve a dual function: identifying program successes, that can potentially be replicated and scaled up, and identifying problems or issues, including incentives that are not properly aligned with care delivery goals or other inefficiencies or areas of weakness that may be vulnerable to gaming or abuse.

As the use of data is central to the implementation of value-based payments, the SIM Office will work closely with the Office of eHealth Innovation to help ensure the safety, integrity and accuracy of data sharing and transfers within the state. SIM will also work with payers, providers, CIVHC (APCD), Stratus, and other data sources to ensure that the data collected to support payment delivery models is accurate, complete and timely.

Colorado SIM is committed to working with state and federal officials to monitor the development of new payment models, identify potential areas of risk, and implement safeguards against any new threats. Through this ongoing

dialogue, SIM hopes to proactively identify potential opportunities for fraud and abuse, and address any issues that arise during the Model Test as expeditiously and effectively as possible.

Component Summary Table

SIM Component/Project Area: *Fraud and Abuse*				
Activity/Budget Item	**Description of activities**	**Vendor** (If known)	**Primary Driver**	**Metric**
Include a clause regarding compliance with state and federal fraud, waste, and abuse laws in all contracts with SIM participating providers	• Develop appropriate language and write into contracts	SIM Office	Practice Transformation; Payment Reform	Executed contracts will contain language regarding compliance with state and federal fraud, waste, and abuse laws
Conduct an ongoing assessment of state and federal fraud, abuse, and other statutes that may pose barriers to integrated care and alternative payment models	• Review state and federal laws regarding: fraud and abuse; anticompetitive behavior; anti-trust; anti-kickback; corporate practice of medicine and physician fee-splitting; and other protections that may pose a barrier to integrated care and alternative payment models • Work with appropriate entities to formulate/request possible exemptions or exceptions to rules that impede integrated care and/or alternative payment models	SIM Office; HCPF; Office of the State Attorney General; CDHS; DORA; DOI; Office of the Inspector General; CMS	Practice Transformation; Payment Reform	Resolve issues as they arise
Work with state and federal officials to evaluate the need for statutory or regulatory actions that may be needed to guard against new fraud and abuse exposures due to changes/reforms in health care system	• Engage in ongoing conversations with state and federal agencies and officials • Evaluate the need to establish a formal mechanism/entity to address statewide issues related to fraud, abuse any other regulations	SIM Office; HCPF; Office of the State Attorney General; CDHS; DORA; DOI; Office of the Inspector General; CMS	Practice Transformation; Payment Reform	Identify issues and develop solutions

Risk Mitigation

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity/Person	Relevant Workgroups
Operational complexities associated with project implementation: • Lack of coordination among SIM Workgroups • Lack of coordination among agencies implementing SIM initiatives • Lack of coordination between SIM and other activities/initiatives in state • Risk of project creep	• Utilize policies and procedures established by SIM Office to facilitate communication and collaboration within and across the SIM governance structure • Develop SIM charter document that clearly outlines roles of each stakeholder workgroup, and disseminate to Workgroups	1	SIM Office	All
Sustaining the engagement of key stakeholders: • Risk of "burn out" among SIM stakeholders from attending multiple meetings/calls • Multiple ongoing health care related initiatives in the state may lead to "reform fatigue" and result in disengagement	• Reduce meeting frequency and length after key decisions are made • Conduct Informal year-end survey of workgroup members to gauge satisfaction with workgroup processes • Post SIM "strategy-on-a-page" documents on SIM website, clearly outlining how SIM-specific activities support the Triple Aim	1	SIM Office	All

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity/Person	Relevant Workgroups
Maintaining multi-payer engagement and alignment	• Participate in monthly meetings of the Multi-Payer Collaborative, to maintain and strengthen payer alignment around SIM goals and objectives • Develop data gathering and reporting systems that will minimize burden on payers • Balance the structural demands of participation in SIM (i.e., requirements around payment models. data collection and reporting) with payers need for flexibility to design alternative payment models that are in line with their unique business needs/resources/philosophies • Work with HCPF to ensure Medicaid payment approaches under Phase II of the Accountable Care Collaborative are in alignment with SIM goals and objectives	1	SIM Office	Payers, Purchasers & Payment Reform
Difficulties/delays related to contracting and procurement processes	• Continue regularly scheduled check-in phone calls, meetings with contractors, to proactively identify issues with timelines, deliverables • Maintain ongoing communication with CMMI • Proactively identify potential sources of delay and develop work-around or mitigation strategies • Standardize the process of on-boarding new vendors and unrestricting restricted funds by using templates and other resources provided by CMMI for efficiency and better communication	1	SIM Office; Contracted Vendors	Practice Transformation; HIT; Population Health; Evaluation
Insufficient number of practices will agree to participate in cohorts of Primary Care Practices, due to the barriers presented by up-front costs associated with integration efforts	• Pursue funding from state foundations, philanthropic organization to expand the practice transformation fund, giving participating practices access to additional capital to help cover initial costs of integration • Identify methods by which the financial incentives associated with Alternative Payment Models can be used to sustain costs of integration	1	SIM Office	Practice Transformation; Payers, Purchasers & Payment Reform

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity/Person	Relevant Workgroups
Data quality	• Build data quality checks into system design • Practice Transformation Organizations will use CHITAs to provide practices with HIT support regarding data entry • Convene a Data Analysis workgroup to map disparate data sources	1	SIM Office	HIT; Practice Transformation
Obtaining necessary data to track progress toward goals	• Utilize multiple data sources and analyses for examining certain questions (i.e. eCQM and claims proxies) • Examine a sub-set of practices • Qualitative methods (key informant interviews)	1	Selected evaluation vendor	Evaluation
Delays associated with obtaining necessary regulatory changes, approvals (i.e. waivers, rule changes)	• Work with HCPF to proactively determine the need for Medicaid waivers • Engage with CMS to expedite Medicare's participation as a payer in SIM's payment reform initiatives • Review Colorado statutes and rules that may pose a barrier to integrated care and work with state agencies, legislators, and other key stakeholders to develop short- and long-term strategies to address needed changes	2	SIM Office	Policy

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity/Person	Relevant Workgroups
State and federal regulations around heath information sharing, including behavioral health records and substance use disorder information	• Draft and distribute a White Paper and/or a one page summary that clarifies the parameters of state and federal law, to distinguish "myth" from reality • Develop and disseminate a statewide interpretation of 42 CFR Part 2, and encourage providers to apply the law in a similar manner across practices • Continue to see additional guidance and clarification from SAMHSA regarding 42 CFR Part 2's implications for behavioral health information sharing and inclusion in HIE • Partner with the Oregon Health Authority to sponsor a webinar on privacy and confidentiality laws, and develop other information and training materials for providers • Work with consumers to address patient concerns regarding privacy and information sharing, and develop information resources that help explain current laws, consent process, etc. • Engage key stakeholders to develop a standard consent form	1	SIM Office	All
Due to the complexity of developing an overall Central Data Hub, a system for collecting Clinical Quality Measures (CQMs) will not be identified in time for first cohort practices to report baseline measures during the first quarter of participation	• Develop a simple, short-term solution for collection of CQMs that will be deployed in time for first-quarter reporting • Identify a manual method of data collection that can be used as a backup, should delays occur • Develop an RFP for a long-term solution for CQM collection, which will build on the data collected via the short-term solution	1	SIM Office	Practice Transformation; HIT; Evaluation

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity/Person	Relevant Workgroups
Capacity of current and future workforce to provide integrated physical and behavioral health care	• Collect data to assess capacity and distribution of current workforce • Work with stakeholders, academic institutions, training programs, and other entities to develop core competencies for primary care physicians, behavioral health providers around the provision of services in an integrated, team-based environment • Develop strategies to strengthen the workforce pipeline	1	SIM Office; Colorado Department of Public Health and Environment	Workforce; Policy
Payment structures and appropriate regulatory environment is not in place to support a new integrated care model with lay health workers and integrated behavioral health and primary care.	• Work with Payers workgroup, the Policy Workgroup, and the Practice Transformation Workgroup to communicate best practices for integrated care teams •Work with RCCOs and HCPF on setting the stage for an inclusive and sustainable integrated care environment	1	SIM Office; OBH; HCPF; RCCOs	All
Associating impact of practice transformation, payment reform, population health and HIT effort with the SIM initiative (differentiating SIM from other initiatives/efforts in state)	• Frame as SIM efforts “contributed to” vs “caused” • Examine differences between practices participating in both SIM and CPCI vs just SIM • Sensitivity analysis • Utilize difference in differences methodology; interrupted time series; “preponderance of evidence” • Longitudinal association	2	Selected evaluation vendor	Evaluation

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity/Person	Relevant Workgroups
Insufficient time to measure impacts of SIM initiatives	• Measure intermediate outcomes • Rapid-cycle feedback and improvements • Examine impact on individual providers and consumers • Analysis at county level • Sub-analyses of high-performing practices • SIM evaluation strategy will include a comprehensive approach that considers process and outcomes measures for specific interventions, thereby providing an alternative indicators of success • Evaluate an approach by which population health measures in counties with a “high saturation” of SIM interventions are compared to those with a low level of saturation, providing a more relevant use of population health data than would monitoring statewide trends alone	2	Selected evaluation vendor; SIM Evaluation Specialist	Evaluation; Population Health
Lack of consensus on competencies and behavioral anchors	• Align efforts with other workforce interest groups in the state • Comply with upcoming executive orders, pending legislation, and provide recommendations based collaborative efforts of SIM and other stakeholders • Develop list of recommended competencies for BHPs generated by the Colorado Consensus Conference • Communicate with NGA when action plan for Workforce is released (anticipated Dec 2015)	2	SIM Office; NGA; BHTC; University of Colorado	Workforce; Policy
Instability in economic, political and regulatory environment (insurance marketplace, state budget, changes in federal regulation, ACA)	• Monitor the legislative, regulatory, and administrative landscape in the state, and proactively identify risks and opportunities for SIM • Work with Governor‘s Office, state agencies, and stakeholders to develop consistent messaging around the key components of SIM, and health care reform efforts in the state • Provide feedback and comments on proposed federal and state regulations, policy changes	2	SIM Office	Policy

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity/Person	Relevant Workgroups
Lack of consensus around SIM policy recommendations/ actions	• Conduct extensive stakeholder outreach/engagement when developing proposed policy recommendations or actions • Utilize a set of tools and standards when developing policy recommendations to ensure a consistent approach and alignment with the overall goals and objectives of SIM	2	SIM Office	Policy
Administrative burden of reporting on CQMs, completing readiness assessments, applying for Practice Transformation funds, participating in Learning Collaboratives, and undertaking other activities associated with participating in SIM will lead to practice burnout	• Practice will receive technical assistance (through CHITAs) to streamline data processes in order to lessen the reporting burden for practice staff • RFAs for cohort participation and Practice Transformation Funds will be kept as simple as possible • In-person Learning Collaboratives will be held just twice a year, for one day each, but will be supported by more flexible learning supports, such as e-learning modules • PTOs will regularly check in with practices regarding level of "fatigue" and report concerns back to the University of Colorado and SIM Office	3	SIM Office; Practice Transformation Organizations	Practice Transformation
Employer demand may not align with the recommendations of SIM or that of the health care community	• Work with the Colorado Department of Labor and Employment and the Colorado Workforce Development Council on resolving disparities between consumer interest, workforce recommendations, and employer demand • Meet with NGA Workforce Workgroup	3	SIM Office; CWDC; NGA	Workforce; Policy
Adequately addressing the needs of underserved and other special populations in the new integrated care model, including intellectual and developmental disabilities.	• Develop strategies for addressing populations that may not be reached through SIM care delivery and payment reform models • Work with Policy Workgroup to develop recommendations	3	SIM Office; NGA; BHTC; University of Colorado	Workforce; Consumer Engagement; Policy

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity/Person	Relevant Workgroups
Loss of key personnel - within SIM Office, governance structure, and other organizations	• Develop robust recruitment and retention policies and procedures • Notify CMMI of changes in SIM Office staff or within SIM governance structure	3	SIM Office	All
Fraud and abuse and other protections may pose an obstacle as care delivery networks and alternative payment models develop and evolve	Engage with state and federal officials in ongoing conversations to review/assess the need for statutory or regulatory amendments and/or exemption or exception provisions	3	SIM Office	Practice Transformation; Payers, Purchasers & Payment Reform; Policy
Efforts and incentives to increase screening may result in providers incorrectly administering screenings, resulting in potential false positives, overdiagnosis, and/or overprescribing	Work with Office of Behavioral Health and other partners to assure providers are trained on accurate and appropriate use of screenings, as well as to disseminate guidelines related to prescriptions (e.g. psychotropic medications for children)	3	SIM Office; OBH	Practice Transformation, Population Health, Consumer Engagement
Offering integrated care may discourage patients who have had a long-standing relationship with a provider from continuing a relationship with that provider, resulting in fragmented care	•Efforts will be made to assess patients' current level of engagement with providers outside the integrated care setting and to encourage continuity of care •SIM-funded Bi-Directional Health homes will be required to demonstrate how their efforts target patients who do not regularly engage with a primary care provider	3	SIM Office; CBHC,	Practice Transformation, Population Health, Consumer Engagement
Care in an integrated setting may be rushed or delivered by a provider who does not have the same level of aptitude in addressing behavioral health issues as would a behavioral health specialist, therefore negatively impacting the consumer experience	• Develop trainings and core competencies for primary care providers who deliver behavioral health care • Require participating providers to implement patient experience surveys and/or utilize Patient Family Advisory Councils to monitor and improve patient experience	3	SIM Office; University; Practice Transformation Organizations; OBH	Practice Transformation, Population Health, Consumer Engagement

Risk Factors	Prioritized Risk Mitigation Strategies	Priority	Lead Entity/Person	Relevant Workgroups
Potential overlap between SIM-Funded Regional Health Connectors and AHRQ-Funded Regional Health Connectors, as well as systems coordination efforts undertaken through the Accountable Care Collaborative initiative	The CHES team, who will oversee AHRQ-funded RHCs, will play a leadership role in deploying SIM-funded RHCs, allowing for coordination rather than duplication of efforts. The SIM Team has scheduled regular meetings with the Accountable Care Collaborative team and will prioritize coordination of efforts	1	SIM Office, CHES	Practice Transformation, Population Health

Conclusion

The Colorado SIM Operational Plan constructs a roadmap for achieving the Colorado SIM goal. The plan defines Colorado SIM's four-pillared approach to transformation, provides a record of key accomplishments and lessons learned to date, identifies specific activities and next steps for ensuring progress, lays out strategies to mitigate risks, and indicates how partnerships can be leveraged to maximize impact. Thanks in large part to the numerous stakeholders who offered guidance and feedback on key elements of the plan, the SIM Office is confident that the document will serve as a practical tool for transforming Colorado's ambitious goal into achievable steps forward. However, the SIM Office also recognizes that, at times, innovation will call for deviating from the charted route. When obstacles arise that challenge the wisdom of the planned course, the SIM Office will look to its valued partners to provide direction in forging a new pathway forward. It is with a pioneering spirit, which balances careful planning with the flexibility to respond to new challenges and opportunities, which Colorado SIM sets out to implement the activities in this plan and chart a course toward a healthier tomorrow.

Acronyms

ACA -- Affordable Care Act

ACC-- Accountable Care Collaborative

ACO -- Accountable Care Organization

ADT -- Admissions, discharge, and transfer system

AHRQ -- Agency for Healthcare Research and Quality

APCD -- All Payer Claims Data

APM -- Alternative Payment Models

ARRA -- American Recovery and Reinvestment Act

BHO -- Behavioral Health Organization

BHP -- Behavioral Health Provider

BPCI -- Bundled Payments for Care Improvement

BSL -- Brookdale Senior Living

CAHPS -- Consumer Assessment of Healthcare Providers and Systems

CALPHO -- Colorado Association of Local Public Health Officials

CARE -- Continuity Assessment Record and Evaluation

CASOA -- Community Assessment Survey for Older Adults

CBGH -- Colorado Business Group on Health

CBHC -- Colorado Behavioral Health Council

CBHTC -- Colorado Behavioral Health Transformation Council

CB-LTSS -- Community Based Long Term Support Services

CCB -- Community Centered Board

CCD -- Continuity of Care Document

CCT -- Colorado Choice Transitions

CCT -- Community Care Team

CDC -- Centers for Disease Control

CDHCPF -- Colorado Department of Health Care Policy and Financing

CDHS -- Colorado Department of Human Services

CDPHE -- Colorado Department of Public Health and Environment

CHA -- Colorado Hospital Association

CHAS -- Colorado Health Access Survey

CHES -- Colorado Health Extension System

CHHC -- Colorado Healthy Hospital Compact

CHIP -- Children's Health Insurance Program

CHITA -- Clinical Health Information Technology Advisor

CHW -- Community Health Worker

CIVHC -- Center for Improving Value in Health Care

CLAG -- Community Living Advisory Group

CMFCA -- Colorado Medicaid False Claims Act
CMHCs-- Community Mental Health Centers
CMMI -- Center for Medicare and Medicaid Innovation
CMS -- Centers for Medicare and Medicaid Services
CORHIO – Colorado Regional Health Information Organization
COUP -- Client Over-Utilization Program
CPA -- Colorado Prevention Alliance
CPC -- Comprehensive Primary Care
CPCI -- Comprehensive Primary Care Initiative
CQMs -- Clinical Quality Measures
CTN -- Colorado Telehealth Network
CWDC -- Colorado Workforce Development Council
DOI -- Colorado Division of Insurance
DORA -- Department of Regulatory Agencies
DPA -- Department of Personnel Administration
DRG -- Diagnosis-Related Group
DSRIP -- Delivery System Reform Incentive Program
DUI -- Driving Under the Influence
ECPs -- Essential Community Providers
ED -- Emergency Department
EHR -- Electronic Health Record
e-LTSS -- Electronic Long Term Services and Supports Standard
EoC -- Experience of Care
EPA -- Environmental Protection Agency
FFS -- Fee for Service
FPL -- Federal Poverty Level
FQHC -- Federally Qualified Health Center
FTE -- Full Time Equivalent
HCIA -- Healthcare Investment Analysis
HCPLAN -- Health Care Payment Learning and Action Network
HES -- Health Extension Service
HFEMS -- Health Facilities and Emergency Medical Services Division
HHS -- Department of Health and Human Services
HIAs -- Health Impact Assessments
HIE -- Health Information Exchange
HIPP -- Healthcare Incentives Payment Pilot
HIT-- Health Information Technology
HITECH -- Health Information Technology for Economic and Clinical Health
HRSA -- Health Resources and Services Administration

HVHC -- High Value Healthcare Collaborative
IPAT --HRSA Integrated Practice Assessment Tool
IPERA -- Improper Payments Elimination and Recovery Act
IPIA -- Improper Payments Information Act
IRS -- Internal Revenue Service
KIIS-- Key Informant Interviews
KPI -- Key Performance Indicator
LAC -- Licensed Addictions Counselor
LPC -- Licensed Professional Counselor
LPHAs -- Local Public Health Agencies
LTPAC -- Long Term and Post-Acute Care
LTSS -- Long Term Services and Support
MCH -- Maternal and Child Health
MDS -- Minimum Data Set
MFCU -- Colorado Medicaid Fraud Control Unit
MMIS -- Medicaid Management Information System
MOU -- Memorandum of Understanding
MPC -- Multi-Payer Collaborative
MPI -- Master Patient Index
MSAs -- Metropolitan Statistical Areas
NAIC -- National Association of Insurance Commissioners
NCCHP -- Northwest Colorado Community Health Partnership
NCHA -- North Colorado Health Alliance
NGA -- National Governor's Association
NICU -- Neonatal Intensive Care Unit
OASIS -- Outcome and Assessment Information Set
OBH -- Office of Behavioral Health
OIT -- Office of Information Technology
ONC -- Office of the National Coordinator
PCEP -- Primary Care Extension Program
PCMH -- Patient Centered Medical Home
PCP -- Primary Care Provider
PDMP -- Prescription Drug Monitoring Program
PERA -- Public Employees Retirement Association
PERM -- Payment Error Rate Measurement
PHR -- Personal Health Record
PMPM -- Per-member per-month
PN -- Patient Navigator
PTOs -- Practice Transformation Organizations

QHN -- Quality Health Network

QHP -- Qualified Health Plans

QIS -- Quality Improvement Strategy

QMRT -- Quality Measures Reporting Tool

RAE -- Regional Accountable Entity

RCCOs -- Regional Care Collaborative Organizations

RFA -- Request for Application

RFI -- Request for Information

RFP -- Request for Proposal

RHC -- Regional Health Connector

RMHP -- Rocky Mountain Health Plan

RSS -- Rich Site Summary

SAMHSA -- Substance Abuse and Mental Health Services Administration

SBIRT -- Screening, Brief Intervention, and Referral to Treatment

SDAC -- Statewide Data Analytics Contractor

SDE -- State Designated Entity

SEP -- Single Entry Point

SHIP -- State Health Innovation Plan

SIM-- State Innovation Model

SMI -- Serious Mental Illness

SPLIT -- Shared Practice Learning and Improvement Tool

SUD -- Substance Use Disorder

TCHF -- The Colorado Telehealth Foundation

TCPI -- Transforming Clinical Practices Initiative

TEFT -- Testing Experience and Functional Tools

UCH -- University of Colorado Health

UNTHSC -- University of North Texas Health Science Center

V-Cap -- Vital Healthcare Capital

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