Colorado SIM Operational Plan Award Year 4 Update

SIM

State Innovation Model

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Contents

A. SIM background **3**

1. Summary of model test 3
2. End state vision 7
3. Updated driver diagrams 13
4. Updated Master Timeline 27

B. General SIM policy and operational areas **44**

1. SIM Governance 44
2. SIM operational areas 49
3. Policy 52
4. Roles and responsibilities of staff and contractors 54
5. Leveraging regulatory authority 59
6. Stakeholder engagement 62
7. Health Care Delivery System Transformation Plan 72
8. SIM alignment with state and federal initiatives 163

C. Detailed workplans by driver **185**

D. Program evaluation and monitoring **185**

1. State-led evaluation 185
2. Federal evaluation, data collection and sharing 190
3. Program monitoring and reporting 192
4. Fraud abuse prevention, detection and correction 202

E. Sustainability plan **206**

1. End-state vision 206
2. Accomplishments to achieve state goals 206
3. Setting us up for sustainability: Reflections from Colorado 207
4. Sustainability: SIM pillars 207

F. Operational plan appendices **212**

A. SIM background

1. Summary of model test

The Colorado State Innovation Model (SIM) operational plan charts a path to achieving SIM's overarching goal: To improve the health of Coloradans by increasing access to integrated physical and behavioral health care services in coordinated community systems, with value-based payment structures, for 80% of Colorado residents by 2019. To turn this vision into a reality, SIM is leveraging a model test award from the Center for Medicare and Medicaid Innovation (CMMI) to implement and expand activities outlined in Colorado's State Health Innovation Plan (SHIP) (see appendix A1), which was created with support from a CMMI Model Design Award.

For SIM, the term "behavioral health care" includes the spectrum of services used to diagnose, prevent and manage substance use disorders, health behavior aspects of disease and mental health. Learn more about the six levels of integrated care that SIM practices use: www.co.gov/healthinnovation/levels-integrated-care.

The initiative continues to chart a path toward success as outlined in this report and in regular updates to the Centers for Medicare & Medicaid Innovation. The team has experienced ongoing challenges with the large scope of the initiative and staff turnover, due to the fast-pace and high-pressure environment of a term-limited initiative with such an ambitious scope. The team is on track to achieve the goals included in the original proposal and continues to expand awareness of the initiative and the work that health care providers and health plans are doing to transform the health care delivery system. The "SIM Reach and Scope" document (https://drive.google.com/file/d/1WczjzfzFgw7ppM9aGkfo_iSAJ94_e935/view) illustrates the investments SIM has made across the state.

The team continues to find new ways to tell stories of the initiative's successes, which will help continue conversations about sustainability, which will continue to be a team focus in the fourth and final year. As outlined throughout this report, evaluation and sustainability plans were built into the SIM framework early on to ensure that all program managers, vendors and participants in SIM were thinking about and planning for ways to sustain the progress made during the initiative. While there is a separate section for sustainability, we have included sections in all areas of focus for SIM to highlight the ways in which the planning and implementation for SIM have led all participants to discuss, plan and research funding for sustainability after July 2019, when the SIM initiative ends in Colorado.

It has taken time to develop action plans for some of the four SIM pillars, yet work is now underway and represents a thoughtful approach to integrating care and succeeding with alternative payment models (APMs) that provide a sturdy foundation for future growth. It has been helpful to chart the challenges, failures and successes along the way, all of which will help other states chart a faster path to delivering whole person care that improves health outcomes, reduces or avoids unnecessary costs and engages patients in collaborative discussions about their care.

The team is proud of the work that has been accomplished, the partnerships that have been established in the state and the collaborative nature of the work that primary care practice sites and community mental health centers are doing in Colorado. This is difficult, time-consuming work that takes a while to show dividends, yet practice surveys show that SIM providers acknowledge whole-person (integrated physical and behavioral health) to be the "right way" to deliver patient care, appreciate team-based approaches as ways to enhance morale and avoid or diminish burnout and many SIM practices say that efforts to improve communication between health plans and provider representatives is paying off.

"We can now say to CMS [Centers for Medicare & Medicaid Services] and to later adopters, 'Your patients are going to have better outcomes because of this work,'" said Donna Lynne, DrPH, Colorado lieutenant governor and

chief operating officer, during the SIM All Stakeholder Convening in February 2018 in Denver. "As you reflect on the last two years and how far we've come with SIM, you should all take a bow."

An overview of the initiative and its goals are outlined here, and more detail is provided throughout the report.

Colorado will work with about 300 practice sites and four community mental health centers to integrate behavioral and physical health in primary care settings and test alternative payment models from 2015 through 2019. The team is also pursuing relationships with the Veteran's Administration and Indian Health Services as outlined in the original proposal. These discussions have been fruitful, and the team continues to develop plans to include these populations in the SIM approach. Practice sites have two years (except cohort 3, which has one year) to work with practice coaches, who help them revise processes and enhance care teams to deliver this "whole-person care," which has been proven to improve outcomes and reduce or avoid costs.

During this final year of the test award, the SIM team will continue to gain insights into the practical challenges of integrating care and helping providers succeed with alternative payment models (APMs) using stakeholder interviews as well as evaluation reports and data analyses as a guide.

Initial successes are attributed to strong collaboration among stakeholders and a shared vision among state leaders for health care transformation. A few examples of success to date:

- Broadband capability expanded by 203 sites across the state at the time of publication;
- 85 primary care practice sites awarded small grant funds to integrate care;
- 95% of practice sites reported on all required SIM measures;
- There is a 96% retention rate for SIM participation;
- After 2 years of participation 94% of cohort-1 practice representatives, who responded to a SIM survey say they would recommend participation to their colleagues; an improvement from 87% of respondents surveyed the previous year;
- 94% of cohort-1 and cohort-2 practice representatives, who responded to the survey say that SIM has helped them integrate behavioral and physical health;
- 81% agreed that access to alternative payment models through SIM participation has helped them achieve their practice transformation goals;
- Continued strong stakeholder interest in the SIM initiative.

Challenges that SIM continues to address:

- Provider initiative fatigue;
- Provider burnout;
- Reporting burden;
- Shortage of behavioral health providers;
- Financial support to sustain gains realized through SIM;
- Technology challenges; and
- Barriers to information sharing that would ensure that providers have access to all relevant patient information.

It is noteworthy that SIM providers report lower burnout rates than national statistics, as cited in CMMI reports, and while there is "initiative fatigue" that is different than overall burnout. Provider burnout is not specific to SIM or any initiative. Research has shown a high rate of medical provider burnout, particularly in primary care, so it is being measured within SIM cohorts to see if integration influences the level of burnout, and we are seeing that it does influence it in a positive way.

a. Progress-to-date

The SIM team continues to collect feedback and refine implementation to ensure future success. Changes to the initiative, made between the start of the second and third cohorts, allow practices to report short-and long-term successes with their progression along an integration pathway. The team aligned clinical quality measures and other aspects of the initiative to ensure that SIM would be complementary, not competitive, to CPC+ and other innovation initiatives in the state. More information about progress along this pathway is outlined in the payment and service delivery models section of the plan.

SIM stakeholders have been engaged at every step as the team made changes to the initiative to vet ideas and create guideposts for sustainable success for practices at all levels of care integration. The work has already proven to be successful as evidenced by comments from practice transformation organizations (PTOs) and practice representatives, who say a focused approach on integration has been helpful and will lead to future success.

For example, this is a quote from a SIM cohort-1 physician: "I will admit, as a primary care physician, we have a tendency to roll our eyes and be very skeptical of new initiatives. In reflecting upon the past year and a half, I have learned a great deal that has impacted my practice. The behavior health aspect has changed the way we treat patients and has allowed primary care to coordinate care with behavior health with "warm handoffs," follow up counseling sessions and calls on new medication starts. This has improved the quality of work we do and has had tremendous feedback from patients as to the benefits of having embedded behavior care. The many projects and goals we have attained through the SIM project has led to better recognition of quality measures and over improved outcomes and care."

Website, social media and newsletter analytics

The team continues to build its social media presence, publishes two newsletters (a general, monthly SIM newsletter and a bimonthly practice newsletter), has started a podcast series and a new blog in 2018, published a video series, and regularly updates its website to share information about integrated care and testing alternative payment models. The SIM team will continue to use social media channels in AY4 to connect with providers, stakeholders and patients in new ways and encourage more discussion about the value of integrated care, and to engage more people in the discussion about changes to the healthcare culture in the state.

Website

- The SIM website had **2,986** unique page views in March 2018.
- A new SIM blog was launched in January 2018 and the number of people who read it has increased incrementally each month to date.
- The most viewed page on the SIM website is the news and media page which brings in over 200 unique pageviews per month.

Social media

- **60.9 K** Twitter impressions so far in 2018.
    - **96** mentions
    - **67** new followers
    - **1,024** profile visits

- Over **3,000 people** have interacted with the SIM Facebook page since January 2018.

Monthly SIM newsletter

- Sent to over **1800** stakeholders
- **33.7%** open rate (22.93% industry average)
- **89 people (or 18.1% of all who opened)** clicked on one or more links

SIM provider newsletter

- Sent to more than **470** stakeholders, primarily SIM practices and practice transformation organizations
- **34.8%** open rate (22.93% industry average)
- **35 people (or 24.6% of all who opened)** clicked on one or more links

Podcasts

- The SIM office began producing a podcast series, *Innovation Insights*, in March 2017. Within the first year, **20** episodes have been produced resulting in **1,421** "plays."

Videos

- The SIM office posted 13 videos to its YouTube channel in the past year, which received **2,681 views**.
  - The most watched SIM video is a quick (less than two minutes) overview of the initiative titled, "What is SIM?" This video has had **716** views to date.

b. Roadshow

The team is working with Arrow Performance Group, a vendor, to engage patients in conversations about integrated care and value-based payment. The goal is to combine efforts to share the work that regional health connectors and local public health agencies are doing to improve community connections, reduce stigma related to mental health and facilitate the integration of behavioral and physical health for practices across the state.

Staff continue to develop a self-insured employer communication outreach strategy and have seen increased interest from the Colorado Business Group on Health (CBGH) and its members. The state recently became a member of the CBGH, and the team hopes to coordinate with state colleagues to highlight some of the work self-insured employers can do to improve health outcomes and reduce or avoid costs with data-based decisions. The team will once again present at the annual Culture of Health conference that CBGH hosts, is scheduled to present at a summer meeting of CBGH members and continues to collaborate with executives from the group to identify ways we can share successes. In the past, the team has presented to the CBGH membership, which resulted in a request for a list of SIM providers to publish on employer websites. The SIM team has also benefitted from a consult with Health Care Strategies and gained valuable insights from the conversations, which have been used in the SIM strategy in Colorado.

c. Action plan

The activities outlined in this operational plan directly reflect Colorado's commitment to engage stakeholders from across the health care spectrum to integrate physical and behavioral health care, improve population health by leveraging public health and community resources, and help SIM practices shift from fee-for-service reimbursement structures to prospective value-based payment models that reward better care outcomes.

This plan outlines Colorado's four-pillar approach to health care innovation:

1. Providing access to integrated physical 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, such as the Comprehensive Primary Care Plus Initiative (CPC+) and the Medicaid Accountable Care Collaborative (ACC). The plan also details how SIM will engage consumers, assess workforce capacity, and use a range of policy and regulatory levers to address 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 continue to allow SIM to identify areas that need improvement in real time and build on existing strategies.[4]

When fully implemented, the plan is projected to generate $126.6 million in total cost of care savings by 2019 with $85 million in continued cost avoidance or savings as a result of the SIM investment. By expanding access to integrated care, SIM is intended to improve the experience of care for consumers 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 will continue to share lessons we learn along the way and have been bolstered by patient testimonials about improved experience of care.

d. Project summary

Goal: Improve the health of Coloradans by increasing access to integrated physical and behavioral health care services in coordinated community systems, with value-based payment structures, for 80% of Colorado residents by 2019.

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

The SIM office accepted 165 cohort-2 practices, and 155 practice representatives signed participation agreements and started their work in September 2017. Another 89 practices were accepted in May 2018 into cohort-3. In addition, the four community mental health centers continue their work during the four-year time frame. The goal, as stated earlier, is to help practices integrate behavioral and physical health and to learn how to succeed with alternative payment models. The team continues to refine its approach with stakeholder input and an ongoing assessment to identify areas of vulnerability and ensure that the SIM initiative provides practice sites with a sustainable plan for integration.

2. End state vision

The SIM team continues to chart successes throughout the initiative, as noted throughout this operational plan, as we strive to improve the health of Coloradans by increasing access to integrated physical and behavioral health care services in coordinated community systems, with value- based payment structures, for 80% of Colorado residents by 2019. The way the team will meet this ambitious goal is through its work with primary care practice sites and community mental health centers as well as through the investments in local public health agencies, regional health connectors and connections made with state agencies that expand the scope and reach of the initiative. During AY4, the SIM team will continue to seek ways to reach its goal and has had successful conversations with the Department of Veterans Affairs and Indian Health Services, which will continue.

In addition to the ongoing evaluations of the program and data reported to CMMI, the SIM team has been bolstered by positive feedback from SIM providers, who continue to say that the investment in integration has

reinvigorated team members, improved patient engagement and health outcomes and helped care teams succeed with alternative payment models. One of the SIM steering committee members told the group that a doctor at a SIM cohort-1 practice had such a positive experience with behavioral health providers on the care team that he is demanding that funding continue for the new hires. "The doctors are adamant that the behavioral health providers had to be part of the care team," said Paul Staley, MA, director network engagement, UCHealth**,** during the April steering committee meeting.

The key element that the SIM team continues to work on with representatives from practices and health plans is how the integration is supported financially. The business supports education and training that is funded by SIM has helped some providers negotiate different contracts with health plans, and the SIM team will continue to highlight the ways in which the work improves health outcomes and reduces or avoids health care costs. In AY4 the team will also continue to focus on how the initiative helps care teams improve practice efficiencies, expand patient access, and provide guidance on how to identify those operational savings and reinvest them in the practice.

The Multi-Stakeholder Symposiums (outlined below) will continue to provide a valuable venue for honest and collaborative dialogue between practices and health plan representatives, who ideally will talk about ways to sustain the work that both groups recognize to be valuable. As care teams recognize their role in ensuring effective, efficient practice processes and the need to communicate the work they're doing toward that end to health plan representatives, there will be more of an opportunity to partner on different payment models that support integrated care that leads to better outcomes. In AY4, the SIM team will continue to highlight how practices can use their data—and the progress they can show with that data—to tell a compelling story to health plans about their unique value. As one physician said last year during a Multi-Stakeholder Symposium, "We now know that we have to prove what we're doing." That is news to some providers, who will continue to use the skills they're learning in SIM to have different types of conversations with health plan representatives.

In AY4, efforts will be focused on sustaining the work that has been started across the state—in practices, communities and community mental health centers. While pieces of that plan are included throughout the document, we have outlined the sustainability plan, which continues to evolve, in the sustainability plan section of this report. The good news is that practices and communities are recognizing the value of the work that SIM has started and expanded across the state and are starting to seek funding streams that would enable them to sustain staff members and resources, which will bolster the SIM team's sustainability plan.

a. Multi-payer participation

The SIM team continues to work closely with the Multi-Payer Collaborative (MPC) to ensure sustainable integration of physical and behavioral health care, address alignment with other programs and reduce provider burden and to improve the partnership between practices and health plans (payers). Team members present data during monthly meetings, discuss priority milestones, worked with the members to establish a "good standing" program for practices and continue to discuss identified priorities to support quality improvement and movement toward value-based payment. The team continues its work to improve communication between payers and providers and has customized communications for payers to send to practices that identify and explain the value-based payments that are used to "support" the work practices do in SIM. The payers also support data aggregation tools that help practices identify cost and utilization trends and risk stratify patients and should help providers negotiate mutually-beneficial contracts that reward value-based care. The Multi-Stakeholder Symposiums that were launched in January 2017, continue to bring payers and providers together with practice transformation organizations (PTOs) to develop a mutual understanding and appreciation for what it takes to transform medical practices and integrate care. The team hosts three Multi-Stakeholder Symposiums annually. The first joint SIM and

CPC+ meeting was held in Grand Junction on April 26, 2018. During this meeting, cohort-1 practice teams have been asked to present some of the work they've done during SIM with PTOs to highlight what types of information they should be sharing with payers. The SIM team has recognized that while practice teams are investing time and energy to transform their practices they are not always communicating that work—and its results—to health plan (payer) representatives. We hope that this meeting will help illustrate why it is important to share that information regularly with payers.

Practices continue to use a data aggregation tool (Stratus™) to identify cost and utilization trends and improve their ability to look at patient populations through a preventive care lens. This tool will complement the coaching practices receive from practice facilitators (PFs) and clinical health information technology advisors (CHITAs) to translate data into actionable information as they deliver whole-person care that improves patient outcomes and reduce or avoid costs, a goal that appeals to payers and providers.

The SIM team will continue to redesign its offering of business supports that help providers succeed in alternative payment models (APMs). This work was outlined in the original plan and is part of the contract with the University of Colorado Department of Family Medicine. The SIM team continues to hear about a need for help with practice budgets, recognizing how you prove a return-on-investment and the ways in which practices can successfully negotiate value-based contracts with health plans as well as practice vendors. The team will continue to revise the business support offered to SIM cohorts to ensure value, and has heard positive feedback from one practice owner, who negotiated a 7% increase in her payment from one payer after communicating a new process that was effectively keeping patients out of the emergency room.

Specific activities have included webinars, train-the-trainer activity to ensure that practice teams gain the skills they need to continue this work once SIM has ended to help practices use data effectively to improve patient health and to prove their unique value with payers. The business supports education that is offered through SIM helps providers negotiate contracts, which will be helpful with health plans as well as EHR vendors. (**See Appendix N1 for examples**).

The SIM team is also working on a communication to electronic health record (EHR) vendors that will come from the governor's office and invite these companies to partner with SIM practices in a new way. The goal is to request that EHR vendors wave fees associated with "customized" reports of the CQMs that are required for SIM participation (and all the other initiatives in the state) in return for recognition that they are "innovation partners," a list that would be published on the state's website. More details about this plan will be forthcoming. The SIM team continues to explore the possibility of joining electronic health record (EHR) affiliate groups, similar to those for CPC+ practices, to help SIM practices capitalize on EHR investments.

The SIM team is making progress with a new consumer engagement strategy to build awareness among consumers about the move from volume- to value-based health care. The goal is to engage consumers differently in their health care so they seek providers who integrate care and become active participants in their care plans and the health care they receive. Our goal is to encourage consumer involvement in the process of practice transformation by acting as informed leaders in SIM workgroups, and in their communities. A new consumer engagement strategy, which was launched in CY3 invests in community liaisons, who will help empower consumers to be active in the SIM initiative and beyond. A survey was distributed to community groups in the spring of 2018 and community meetings will be planned during the summer of 2018.

b. Value-based payment models

SIM will measure its ability to influence the expansion of alternative payment models (APMs) by working with

payers to obtain the number of practice sites participating in APMs and the percentage of patients in each level as outlined in the HCPLAN. This has been a struggle for the SIM team though ongoing efforts are proving fruitful, and the evaluation team has developed a new template that should expedite information gather. More information about this is outlined in the program reporting and monitoring section. The SIM team published a payer framework online that outlines the different APMs that payers are using to support SIM practices and created a new web page that contains information for health plans.

c. Coordinated care from providers who are accountable for quality and total cost

SIM practices receive monthly coaching support from PFs and CHITAs, who help care teams assess processes. One coach described herself as a translator because, she said, she helps practices "prove" that they deliver high-quality care by accessing data and processes to identify areas for improvement as well as celebration as teams make improvements that will help them sustain their efforts.

Practices are required to report CQMs (Appendix B1), and the SIM team has learned a great deal about the challenges practices face with using EHRs to support these efforts. In year 4 the team hopes to continue to dig into this issue and identify ways to help practices use EHRs as effective tools to collect, report, and analyze their CQMs. These CQMs were streamlined in year-2 to align with other federal initiatives and reduce provider reporting burden. These efforts have been well received by providers, who cite the time it takes to report data in different ways, and appreciate the fact that SIM sought out synergies between federal programs in this effort.

The SIM team is moving forward with its efforts to support a statewide repository for the collection and use of CQMs, which is outlined in detail in the HIT section. This will contribute to the team's sustainability efforts.

SIM practices received their first customized cost and utilization reports in April 2017, and licenses to the Stratus™ data aggregation tool in May of that year. All cohorts will have access to this data aggregation tool including continued access for cohort 1 practices even after their active participation in SIM is completed. These complementary tools help SIM practices assess utilization and costs and compare themselves with groups in their specialties and regions. A comparison of these tools (Appendix B2) helps practices identify opportunities for improvement as well as a unique value that they can communicate with health plans.

d. Population health and health system transformation

The SIM initiative continues to expand its reach across the state through investments in local public health agencies (LPHAs) and regional health connectors (RHCs), a new workforce that helps care teams identify and connect patients to community resources (see plan for improving population health section).The SIM initiative also serves as a model for new state initiatives, such as the Team-Based Care (TBC) Initiative, and others.

SIM will be able to measure these aligned efforts for the greatest collective impact through a "Coordinated Community Systems Index" created by TriWest, the state's independent evaluator, that is expected in the summer of 2018. It was originally expected in the fall of 2017. The index will combine data from these sources: key informant interviews with LPHAs, behavioral health transformation behavioral health transformation collaboratives (BHTCs), and RHCs, a monthly RHC report data from the Colorado Health Institute (CHI), a quarterly LPHA and BHTC grantee report data from CDPHE, a network analysis from CHI, environmental scan findings from Health Management Associates, as well as population health indicators and Colorado Health Access Survey data. Themes will focus on collaboration efforts and ratings at the community level. Data will be associated with SIM practice sites and community mental health centers (CMHCs) in communities to assess the degree of coordination between population health partners' efforts, SIM practice sites and CMHCs. More information about the index can be found in the defining and measuring coordinated community systems part of the evaluation section.

SIM's population health workgroup commissioned an environmental scan and gap analysis (**Appendix C1**) to identify behavioral health integration initiatives in the state. More information about this work can be found in the plan for improving population health section.

e. Transformed health information technology and analytics statewide

The SIM office has spent a significant amount of time researching the needs and challenges of creating a health information technology (HIT) strategy that will help SIM practices achieve their goals and contribute to a statewide solution. The team works with several state agencies, including the Office of eHealth Initiatives, the Office of Information Technology and others to align efforts and build on existing frameworks.

The HIT strategy includes a telehealth plan that will help extend patient access to integrated care. The SIM team gathered a group of subject matter experts to discuss successes and challenges with existing telehealth programs across the state and is collaborating on a solution that fits SIM's goals and helps pave the way for sustainability. The SIM office's HIT work acknowledges the challenges with information and sharing that can help or hinder payment reform and delivery reform efforts. The HIT programs related to data extraction and aggregation emphasize interoperability and leverage existing technology and infrastructure to promote a sustainable and modular solution that meets and adapts to changing needs that will continue to be addressed after the SIM initiative ends. With the eCQM and data aggregation solutions that SIM has funded and developed, we can expect to see the following results: Providers share data with minimal effort, payers trust the data and release performance-based payments, behavioral and physical health providers can share data (with patient consent) to provide care that is appropriate and effective. Learn more about these ongoing efforts, which will continue to take shape, in the HIT section.

f. Overall summary

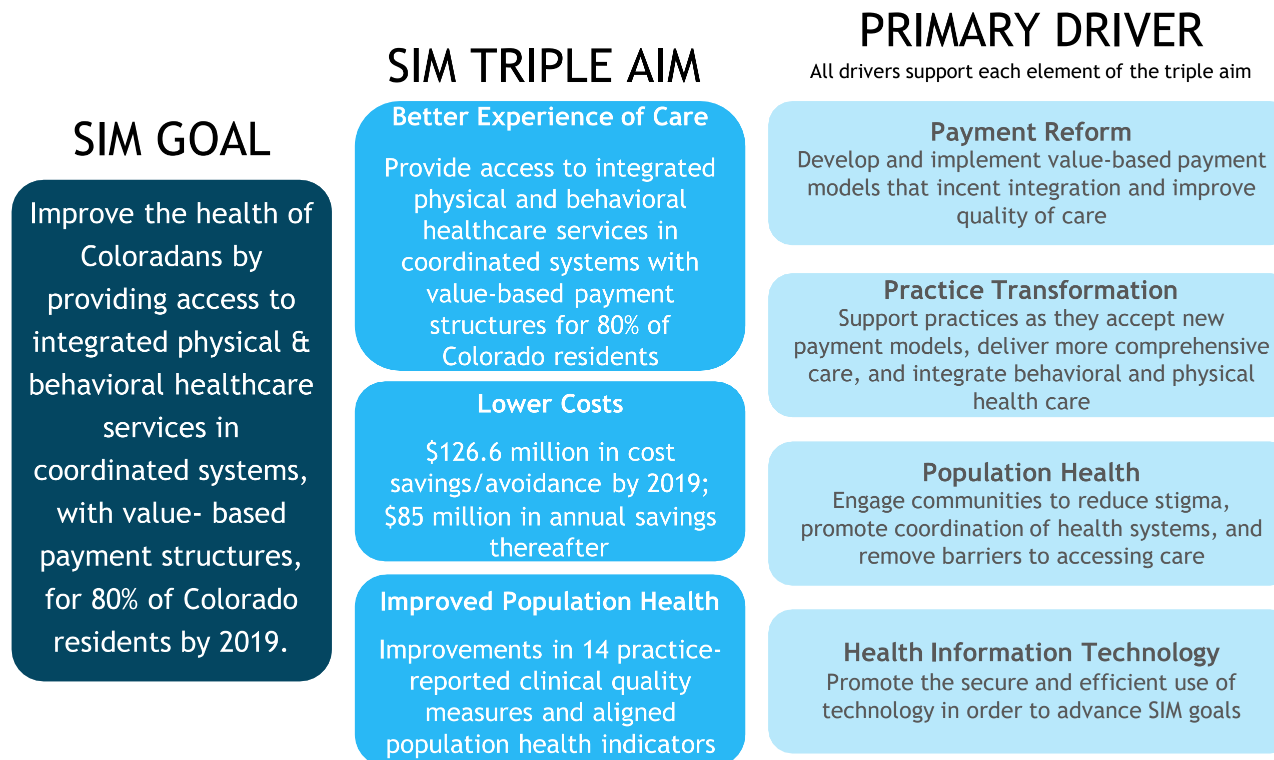
The SIM office has worked closely with a large group of stakeholders to ensure that the four-year initiative to integrate behavioral and physical health and help providers succeed in APMs lays the groundwork for sustainable success. The team continues to work closely with representatives from practices, health plans, and practice transformation organizations to improve communication about what it takes to integrate care, how integration improves health outcomes and avoids or reduces health care costs and the ways in which practices can collect, report and use data to negotiate mutually-beneficial, value-based contracts with health plans. Success in each of these categories relies on developing new skill sets and redesigning traditional approaches to delivering health care. The first year and a half of implementation helped the team identify areas for improvement, which were addressed for the second and third cohorts and reinforced the value of the multi-stakeholder approach to practice transformation work.

The Colorado team is in a unique position to test this model that encompasses all aspects of the health care delivery system, and the involvement of public and private payers. Each payer uses its own APM to support the work that SIM practices are doing, and their involvement in the Multi-Payer Collaborative (MPC), commitment to streamlining quality metrics and providing access to data aggregation opens new doors for effective dialogue between these partners to ensure the sustainability of integration efforts. A key aspect of SIM's practice transformation efforts is the focus on practice coaching that helps build on the unique elements of each practice and identifies areas for improvement. Because quality improvement teams work with coaches to identify project areas, these team members buy into the process, see the results of their efforts and the effects on patients, which inspires them to continue the work. The SIM team will continue to create opportunities for practices to explain the work they've done in SIM during Multi-Stakeholder Symposiums to demonstrate their unique value to health plans and illustrate the work they've done to transform their practices.

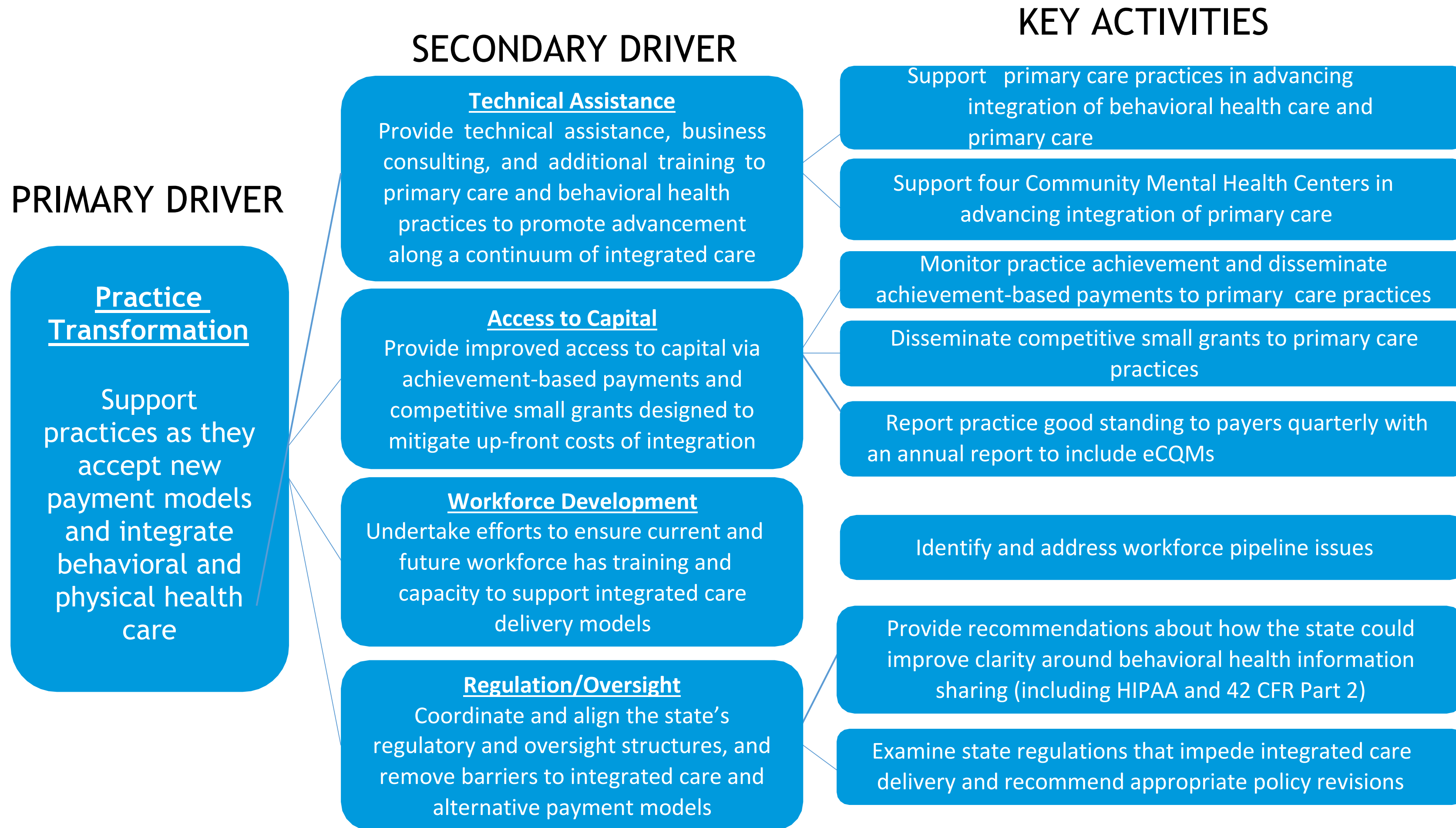
Providers recognize the value of integrated care, which they describe as the "right way to care for patients," and acknowledge that delivering "whole-person care" helps improve outcomes, reduce or avoid costs, and enhance the morale of care teams. This integration work forges new pathways in health care circles because it prompts providers, payers and patients to reevaluate traditional roles and embrace change, which is difficult to do and harder to sustain. The Multi-Stakeholder Symposiums helped change the dynamic for cohort-1 practices and the team will continue its work to encourage cohorts 2-3 to follow the same path. Articles about these meetings are published online: www.colorado.gov/healthinnovation/news-7

The SIM team continues to see data that reinforces early signs of success and believes that as health care providers experience the rewards of providing integrated care and can prove the value of providing this type of care to health plans, whole-person care will become recognized as the best way to deliver health care and payment options that support it will be more accessible. The team also believes that early indications of a positive financial return-on-investment for SIM in the first six months of the initiative will lead health plans to embrace this approach to care as they continue and expand their payment models.

3. Updated driver diagrams



a. Practice transformation



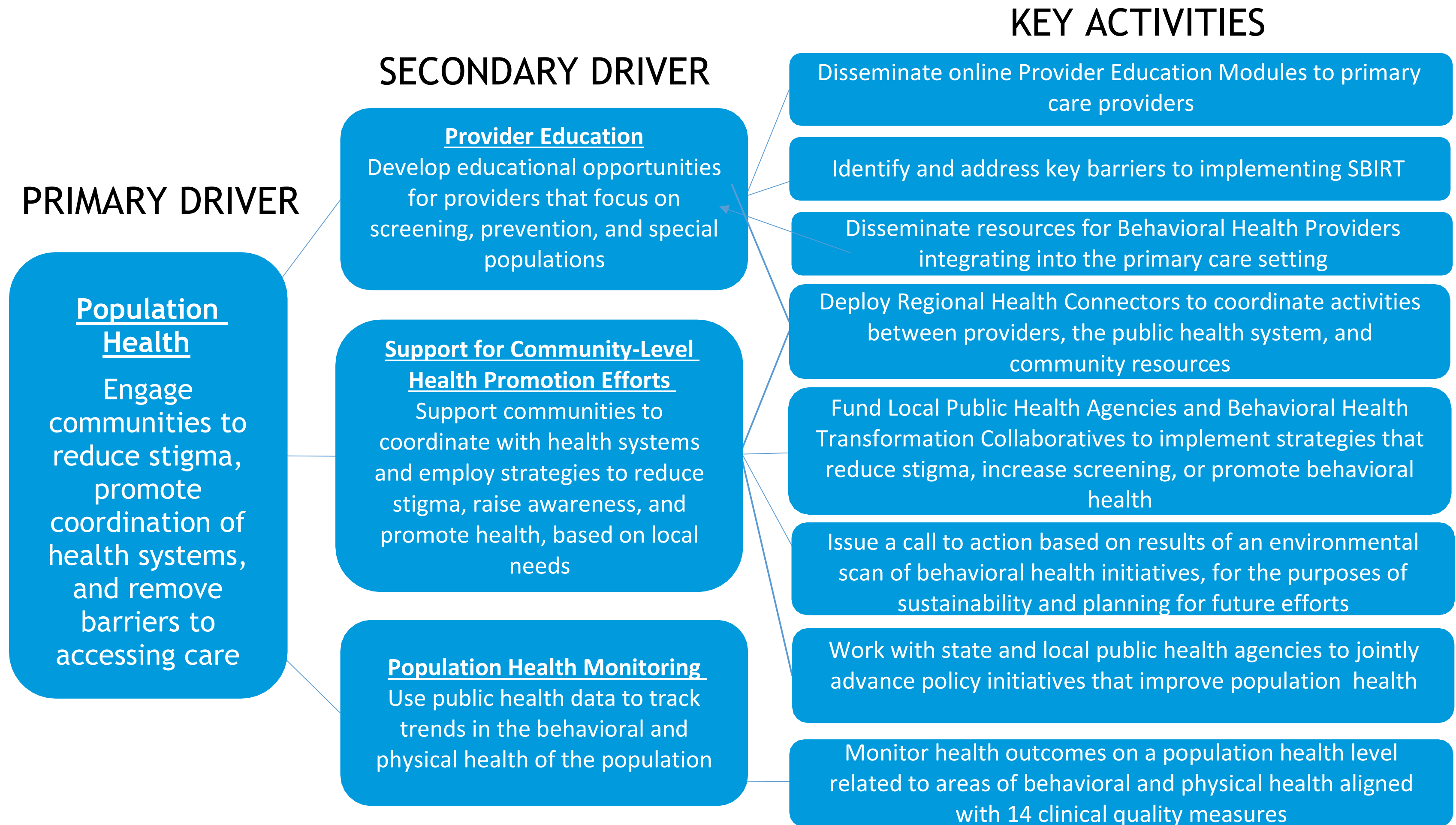
TECHNICAL ASSISTANCE	Support primary care practices in advancing integration of behavioral health care and primary care
	Continue to support 247 SIM-participating primary care practices from SIM cohorts 1 & 2.
	Onboard at least 75 primary care practices to participate in SIM cohort 3 in June 2018.
	Continue to provide limited support to cohort 1 through communication, access to e-learning modules and participation in the collaborative learning forums.
	Train Practice Transformation Organizations (PTOs) to support to SIM-participating primary care practices. Focus PTO support on implementation of the revised 10 Practice Transformation Building Blocks.
	Hold twice-yearly Collaborative Learning Sessions for participating practices.
	Align SIM practice transformation support with support offered by CPC+ for practices participating in both initiatives.
	Disseminate online training modules to support SIM-participating practices in achieving greater integration.
	Support four Community Mental Health Centers in advancing integration of primary care
	Colorado Behavioral Health Council to continue supporting four community mental health centers, including progression along the revised Practice Transformation Building Blocks.
	Sites to report data to CIVHIC as required.
	Sites continue to support patients who are enrolled in the integrated care model.
	Sites to propose sustainability plans including a template for re-creation of their models for other CMHC’s to integrate primary care, both in the state and beyond.

ACCESS TO CAPITAL	Monitor practice achievements and disseminate achievement-based payments to primary care practices
	Follow Milestone Attestation Checklist (MAC) of key practice transformation activities and milestones tied to achievement-based payments of up to $13,000 for cohort-2 practices and disseminate payments to practices via The University of Colorado Department of Family Medicine.
	Follow Milestone Attestation Checklist (MAC) of key practice transformation activities and milestones tied to achievement-based payments of up to $6500 for cohort 3 practices and disseminate payments to practices via The University of Colorado Department of Family Medicine.
	Practices will complete the MAC at the halfway point to see where they need to improve to make it to "good standing.
	Report practice good standing to payers quarterly with an annual report to include eCQMs
	Disseminate competitive small grants to primary care practices
	Collect final reports from cohort-1 practices who were selected to receive Small Grants by May 2018.
	Work with partners at The Colorado Health Foundation and other key stakeholders to revise the Small Grants Request for Application (RFA) based on feedback.
	Fund approximately 30 cohort-2 practices with small grants of up to $40,000 to implement behavioral health integration goals outlined in their practice improvement plans.
	Release small grants RFA in summer 2018 and fund approximately 30 cohort-2 practices with small grants of up to $40,000 to implement behavioral health integration goals outlined in their practice improvement plans.
	Report practice good standing to payers quarterly with an annual report to include eCQMs
	Practices will work toward “good standing” by achieving milestones as shown through the Milestone Attestation Checklist (MAC).
	Provide list of practices that are not in good standing to payers on a quarterly basis. Individual payers will determine how practice standing may affect payments.

WORKFORCE TRAINING AND DEVELOPMENT	**Identify and address workforce pipeline issues ***
	Use the new Colorado Department of Public Health and Environment (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	**Provide recommendations about how the state could improve clarity around behavioral health information sharing (including HIPAA and 42 CFR Part 2)**
	Convene a group of subject matter experts to provide recommendations to the State about the need and process for producing state-level guidance on 42 CFR Part 2.
	Coordinate with other State agencies (OBH, HCPF, and OeHI) on 42 CFR Part 2 efforts.
	Examine state regulations that impede integrated care delivery and recommend appropriate policy revisions
	Monitor scope of practice and licensure requirements.
	Compile and disseminate resources that providers can use to address policies that impede delivery of integrated care.
	Work with Colorado Department of Health Care Policy and Financing (HCPF) to evaluate the need for potential Medicaid waivers or state plan amendments (i.e., Section 2703 Health Homes).

* Please see the Health Resources and Services Administration (HRSA) and the Health Information Technology sections for more information on work being done around workforce pipeline issues.

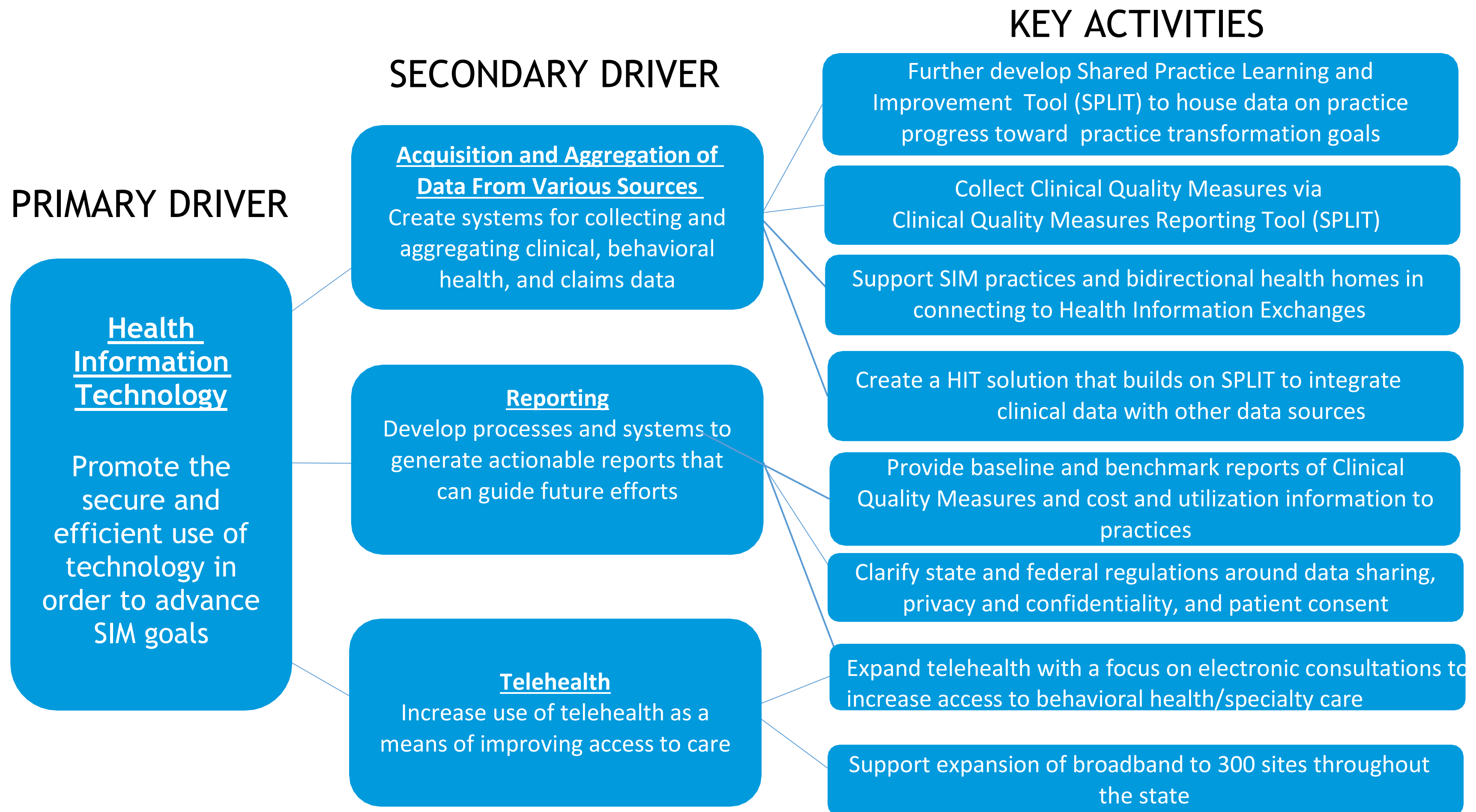
b. Population health



PROVIDER EDUCATION	**Disseminate online Provider Education Modules to primary care providers**
	CDPHE to disseminate online training modules that address pregnancy-related depression, obesity & depression, and depression in men to at least 100 primary care providers.
	Office of Behavioral Health (OBH) to disseminate online courses related to substance use disorders, behavioral health in the senior population, and trauma-related issues, to at least 100 primary care providers.
	Identify and address key barriers to implementing SBIRT
	OBH to conduct an environmental scan of practices to determine key barriers to implementing SBIRT and make recommendations on how to address these barriers.
	Disseminate resources for Behavioral Health Providers integrating into the primary care setting
	OBH to compile a resource outlining best practices for behavioral health providers working in the primary care setting.
	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.
POPULATION HEALTH MONITORING	**Monitor health outcomes on a population health level related to 12 areas of behavioral and physical health**
	CDPHE to provide 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 SIM Office, will continue to update an electronic, interactive display of population health metrics (VISION tool: https://www.colorado.gov/pacific/cdphe/vision-data-tool) that divides data based on demographics (county, age, etc.) for practices, LPHAs, and other relevant organizations to identify areas of high need.

SUPPORT FOR COMMUNITY-LEVEL HEALTH PROMOTION EFFORTS	**Deploy Regional Health Connectors (RHCs)**
	Colorado Health Institute will support and provide technical assistance to 21 RHCs.
	Continue to develop standardized training for RCHs.
	After selecting host organizations to house RHCs in local communities, work with hired RHCs to develop and set three priority areas of focus for their region.
	Fund Local Public Health Agencies (LPHAs) and Behavioral Health Transformation Collaboratives (BHTCs) to implement strategies that reduce stigma, increase screening, or promote behavioral health
	CDPHE to continue disseminating funds to eight (8) LPHAs and two (2) regional BHTC awardees and monitor progress toward goals.
	The SIM office will continue to create and support collaboration between funded LPHAs, RHCs, and SIM practices regarding coordination of complementary activities and initiatives.
	CDPHE will work with Health Management Associate to conduct an environmental scan to assess non-SIM-related behavioral health initiatives across the state. This scan will serve to inform the population health workgroup of gaps or overlapping efforts and inform future efforts of the workgroup and program planning.
	Issue a call to action based on results of an environmental scan of behavioral health initiatives for sustainability and planning for future efforts
	The SIM office will contract with Health Management Associates to produce a call to action, based on gaps identified in the environmental scan conducted during the NCE.
	The population health workgroup will advise on the best way to disseminate the call to action and convene interested partners to discuss next steps.
	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.

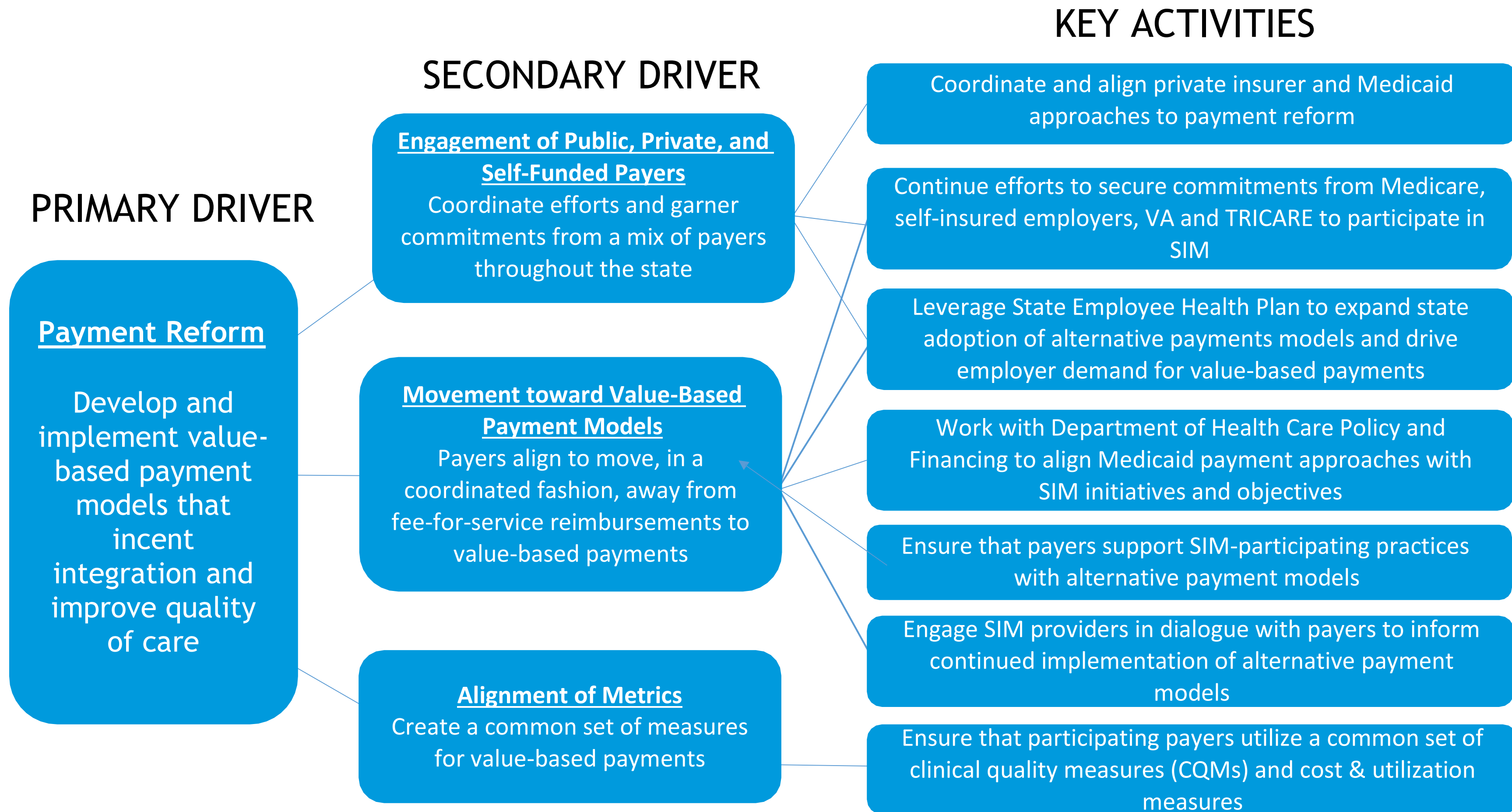
c. Health information technology



ACQUISITION AND AGGREGATION OF DATA FROM VARIOUS SOURCES	**Redevelop Shared Practice Learning and Improvement Tool (SPLIT) to house data on practice progress toward practice transformation goals**
	Work with University of Colorado Department of Family Medicine to continue the development and support the Shared Practice Learning Improvement Tool (SPLIT).
	Train Practice Transformation Organizations on use of redeveloped SPLIT.
	SIM Cohorts 1, 2, and 3 practices submit assessments and relevant data via SPLIT.
	Collect Clinical Quality Measures via Clinical Quality Measures Reporting Tool (SPLIT)
	Collect Clinical Quality Measures (CQMs) from SIM-participating practices via SPLIT on a quarterly basis.
	Create a HIT solution that builds on HIE Infrastructure to integrate clinical data with claims data and other data sources
	Convene subject matter experts to make a recommendation on infrastructure design
	Work with HIEs to integrate other data types such as Social Determinants of Health (SDoH) and PDMP data
	Work with CIVHC and TeleDoc vendors on claims and clinical data aggregation use cases
	Support practices in connecting to Health Information Exchanges (HIEs)
	Use results of SIM HIT assessments to target SIM practices not connected to the HIEs.
	Work with Quality Health Network and CORHIO to promote increased connectivity between SIM practices and Behavioral Health Providers.

REPORTING	**Provide baseline and benchmark reports of Clinical Quality Measures to practices**
	Train clinical health information technology advisors to support practices in accessing and interpreting benchmark reports.
	Continue to provide practices with their clinical quality measures, including a comparison to practice baseline over time.
	eCQM data is extracted and reported into SPLIT and Medicaid
	Create an HIT solution that builds on SPLIT to integrate clinical data with claims data
	Work with stakeholders to determine fields that are most useful to include in for reporting back to practices.
	Explore the expansion of SPLIT to include Provider level reporting to Colorado Medicaid Accountable Care Collaborative Program
	Clarify state and federal regulations around data sharing, privacy and confidentiality, and patient consent
	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.
TELEHEALTH	**Expand telehealth with a focus on electronic consultations to improve access to behavioral health/ specialty care**
	Engage stakeholders to understand current e-consult capacity, investment needs, and interest in expanding networks in rural and underserved areas.
	Improve access to behavioral health and specialty care by funding the expansion of electronic consultation networks with a focus on rural and underserved areas.
	Continue to engage strategic partners to ensure the success and sustainability of SIM telehealth/electronic consultation efforts.
	Support expansion of broadband to 300 sites throughout the state
	Continue working with Colorado Telehealth Network (CTN) to identify potential sites from SIM Cohorts for expanded broadband.
	Work with CTN and the Office of Broadband to assist sites in acquiring subsidies and navigating process of expanding broadband access.

d. Payment reform



ENGAGEMENT OF PUBLIC, PRIVATE, AND SELF-FUNDED PAYERS	**Coordinate and align private insurer and Medicaid approaches to payment reform**
	Leverage Multi Payer Collaborative and Multi-Stakeholder Symposiums to align efforts of public and private payers involved in SIM.
	Payers to continue working toward goals stated in Memorandum of Understanding with SIM office outlining commitment to alternative payment models during bimonthly meetings of the Colorado Multi Payer Collaborative.
	Continue efforts to secure commitments from Medicare, self-insured employers, VA and TRICARE to participate in SIM
	Engage in ongoing conversations with CMS regarding Medicare participation in the state in unique ways, in collaboration with their all-payer unit
	Continue engaging the Colorado Business Group on Health, an organization representing more than 30 self-funded groups from across the state, to explore the expansion of integrated care and alternative payment models (APMs) to this market segment.
	Leverage state employee health plan to expand state adoption of APMs and drive employer demand for value-based payments
	Continue to work with the Department of Personnel Administration (DPA) regarding the use of contractual language/stipulations regarding integrated care and APMs as part of the state employee health plan re-procurement process.

MOVEMENT TOWARD VALUE-BASED PAYMENT MODELS	**Work with Department of Health Care Policy and Financing to align Medicaid payment approaches with SIM initiatives and objectives**
	The SIM office will participate in HCPF planning and discussions around proposed payment models for ACC Phase II and other proposed initiatives as they arise.
	Explore and assess feasibility of an all payer model and a statewide APM opportunity for primary care providers.
	Engage SIM providers in dialogue with payers to inform continued implementation of alternative payment models
	Convene three in-person Multi Stakeholder Symposiums that provide payers, practice transformation organizations, and providers with an opportunity to discuss and inform implementation of APMs.
	Continue to address payment reform topics during bi-annual Collaborative Learning Sessions.
	Payers support SIM participating practices with APMs
	The SIM office will engage with the University of Colorado and payers around onboarding for practices in cohort 3.
	Payers to review practices accepted into SIM cohorts to determine which practices within their provider networks they will support with APMs.
	Payers to reach out to supported practices and negotiate agreements around APMs.
ALIGNMENT OF METRICS	**All participating payers utilize common set of clinical quality measures (CQMs) and cost & utilization measures**
	Participate in the Multi Payer Collaborative (MPC) quality measures alignment workgroup to continue to align quality measures across payers and programs.
	The SIM office will report SIM CQMs to payers annually.
	Report cost and utilization measures to each practice site.
	Work with members of the multi-payer collaborative to provide and support a data aggregation solution to SIM primary care practices that reflects payer data.
	Work with payers to collect data for state and federal evaluation needs.

4. Updated Master Timeline

Governance, Management and Decision Making *Goal: Oversee, coordinate and ensure success of all SIM project deliverables*	Year 2 (Feb. 2016 – Jan. 2017)				NCE (Feb. 2017 – Jul. 2017)		Year 3 (Aug. 2017 – Jul. 2018)				Year 4 (Aug. 2018 – Jul. 2019)				Changes, Short Description
	Q1	Q2	Q3	Q4	Q5	Q6	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Convene Advisory Board Meetings	x	x	x	x	x	x	x	x	x	x	x	x	x	x	On track; Advisory Board will continue to meet every other month in AY4.
Convene Steering Committee Meetings	x	x	x	x	x	x	x	x	x	x	x	x	x	x	On track; Steering Committee will continue to meet every other month in AY4.
Convene SIM Workgroup Meetings	x	x	x	x	x	x	x	x	x	x	x	x	x	x	On track; all workgroups continue to meet quarterly (with exception of the payment reform workgroup. This workgroup was repurposed because much of the conversation was taking place during the Multi-Stakeholder Symposiums as described in the governance section).

Stakeholder Engagement *Goal: Ensure the active engagement of all stakeholders, including but not limited to payers, providers and key contractors*	Year 2 (Feb. 2016 – Jan. 2017)				NCE (Feb. 2017 – Jul. 2017)		Year 3 (Aug. 2017 – Jul. 2018)				Year 4 (Aug. 2018 – Jul. 2019)				
	Q1	Q2	Q3	Q4	Q5	Q6	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Monthly SIM Newsletter (all stakeholders)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	On track (changed from quarterly to monthly based on stakeholder feedback)
Bimonthly Newsletter to Providers			x	x	x	x	x	x	x		x	x	x	x	On track (new activity added since original operational plan).
SIM Charter outlining stakeholder workgroup objectives posted to SIM website [(https://www.colorado.gov/healthinnovation/workgroups)](https://www.colorado.gov/healthinnovation/workgroups)	x														Complete.
SIM to co-host Medical Home Community Forum	x	x	x x x	x	x	x	x	x	x	x	x	x	x	x	On track; the forum continues to convene quarterly. The SIM Population Health Program Manager will take point on coordinating forums in AY4.
Articulation of SIM Strategies	x														Complete.

SIM Outreach Tour						x				x					Outreach tour postponed with delayed launch of cohort 2. Stops to be made in non-metro locations throughout 2017. While outreach was conducted throughout 2016 on an ad hoc basis, a formal tour was not executed during this time.
Identification of strategies to Directly Engage Consumers (e.g. during SIM Outreach Tour, consumer section of SIM website, via existing consumer groups, CE Workgroup, etc.)							x	x	X	X	X	X	X	X	On track. The SIM office anticipates adding consumers to SIM workgroups in AY4.
Convening of Annual SIM Conference											x				SIM All -Stakeholder Convening was held February 22, 2018 in Denver, Colorado.
Public Comment Logs (include a list of comments submitted via the SIM website and public comment made at meetings) maintained by SIM Office	x	x	x	x	x	x	x	x	x	x	x	x	x	x	On track, public comment logs continued.
Population Health Plan ***Goal: To develop and execute on a plan for improving population health with Governor's Office, key state agencies and stakeholders***	**Year 2 (Feb. 2016 – Jan. 2017)**				**NCE (Feb. 2017 – Jul. 2017)**		**Year 3 (Aug. 2017 – Jul. 2018)**				**Year 4 (Aug. 2018 – Jul. 2019)**				**Changes, Short Description**
	Q1	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	
Regional Health Connectors (RHCs)															
First RHC Cohort Selected	x														Complete.
Second RHC Cohort Selected		x													Complete.
Third RHC Cohort Selected			x												Complete.
RHC Annual Workplan	x						X				X				On track.
RHC Quarterly Meetings	x	x	x	x	x	x	x	x	x	x	x	x	x	x	On track.
Convening of RHC Technical Advisory Group					x	x	x	x							The TAG was dissolved in Dec. 2017. TAG was designed as a one-year commitment from key partners involved in the design and implementation of the RHC program. A RHC Sustainability group was created to focus more on the RHCs, host organizations and sustainability. Complete.

Activity															Status
RHC Quarterly Reports	x	x	x	x	x	x	x	x	x	x	x	x	x	x	On track; reports include key metrics. As of February 2018, reports will include updates on meaningful RHC contacts broken down by sector.
RHC Final Report and Sustainability Plan														x	On track. Workplans are due annually, as noted above, whereas this activity will occur once during closeout and is noted as such in 2019.
Grants to Local Public Health Agencies (LPHAs)															Delay of funding release from CMMI pushed timelines related to grantees back in AY2. (Budgets were submitted to OAGM but took more than four months to be unrestricted. Delays were, in part, due to challenges to resolve “unallowable” expenses. Additionally, the volume of requests coming in to OAGM from other states created substantial delays). Work is now on track.
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	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	x	
Provider Education															
CDPHE Provider Education Plan reviewed and finalized	x						X								Plan was revised and approved in Sept. 2017. Complete.
Launch of Obesity and Depression, Depression in Men, and Pregnancy-Related Depression (PRD) modules		x				x				X					PRD module released, others delayed due to contracting issues. Obesity & Depression and Depression & Men modules are due to be released in June 2018.
Dissemination of online training modules			x	x	x	x	x	x	x	x	x	X	x	x	PRD module released, others delayed due to contracting issues. Obesity & Depression and Depression & Men modules are due to be released in June 2018.
Provide information and resources about pregnancy and substance use to all providers involved in the SIM initiative			x												Complete
Distribute state guidelines for psychotropic medications for children						X	X								Psychotropic medication module complete and hosted on CU e-Learning website. New 2017 guidelines final report published in Oct. 2017. Complete.
Develop an on-line substance use disorder course for primary care providers						x	x								Substance use disorders training modules was designed in three separate and complementary segments. Complete.
Enhance and expand the work of SBIRT								x	x	x	x	x	x	x	On track.

Develop an education course to address trauma and trauma related issues								x	X						Delay with funding and holiday schedule. Trauma module was released in February 2018. Seniors module released in March 2018. A complementary Seniors module is being developed and anticipated to be released in August 2018.
Develop on-line course for senior behavioral health issues and intervention strategies									x	X					
Develop a voluntary certificate for Integrated Behavioral Health Staff							x	x	x	X					On track; Curriculum for Certificate was presented at the Second Behavioral Health Consortium in February 2018. The bundle of courses and Certificate of Completion will be promoted at 2018 Symposium.
Develop a set of Best Practice Guidelines for Behavioral Health staff working in Health Settings.											x	X			On track.
Convene best practices symposium for Behavioral Health											X	X			On track.
Environmental Scan and Call to Action															
CDPHE to identify vendor and scope of work for environmental scan						x									Complete.
Vendor to conduct key information interviews and a literature review and report out on the environmental scan that identifies gaps and opportunities for sustainability of SIM goals				x	x	x									Complete.
Prepare a written call to action that addresses multiple sectors and potential resources for recommended activities									x						Complete.
CDPHE and SIM Office to support adoption of call to action and identify appropriate actions that promote sustainability based on findings of the environmental scan									x	x	x	x			On track; specific steps will be identified based on results from activity above.

Practice Transformation Plan *Goal: Provide intensive support to practices to integrate behavioral health and primary care*	Year 2 (Feb. 2016 – Jan. 2017)				NCE (Feb. 2017 – Jul. 2017)		Year 3 (Aug. 2017 – Jul. 2018)				Year 4 (Aug. 2018 – Jul. 2019)				Status
	Q1	Q2	Q3	Q4	Q5	Q6	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	

Practice Transformation Organizations (PTOs)															
Onboarding and training for PTOs	x														Complete. All PTOs have been selected and trained. No new PTOs will be accepted.
PTOs matched to primary care practices	x						x			x					Complete for cohort 1. PTO matching for cohorts 2 and 3 was postponed in accordance to the delayed start of these cohorts. Complete.
PTOs conduct readiness assessments using Shared Practice Learning Improvement Tool (SPLIT)			x	x			x				x				Complete for Cohort 1. Assessments for cohorts 2 and 3 were postponed in accordance with the delayed start of these cohorts. The Readiness Assessment for Cohort 1 is included as Appendix T1.
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	x	x	x	On track; all cohort 1 and cohort 2 practices are currently matched with a PTO; Cohort 3 practices will be matched by August 2018. Complete.
SIM Office convenes regular PTO Office Hours				x	x	x	x	x	x	x	x	x	x	x	On track; new activity added since original operational plan.
Practice Transformation Primary Care Cohorts															
Update Project Management/Operational Plan						x				x					Complete.
Practice Cohort 1 practices selected and onboarded	x														Complete.
SIM Implementation Guide and Toolboxes available to Cohort 1 practices	x														Complete.
Revisions made to Implementation Guide and Toolboxes to reflect revised Practice Transformation Building Blocks						x									New activity added since original operational plan. Marjie Harbrecht has been contracted to support this work and a practice algorithm for implementation has been drafted. Complete.
E-Learning courses disseminated (released incrementally)	x	x	x	x	x	x	x	x	x	x	x	x			On track; six modules live on SIM e-learning website. SIM practices also have access to 4 HIT modules and 12 PCMH modules.
Practices convene for Collaborative Learning Sessions (CLS)		x		x				x		x		x	x		On track; Cohort 1 practices have attended two CLS events thus far. Cohort 2 practices began attending CLS events in November 2017. Cohort 3 will begin to attend CLS events in October 2018.
Define method of determining which practices are in "good standing" under revised SIM framework and milestones						x									On track; the SIM Office is working with partners at the University to outline these criteria. An explanation will be included in all notification packets to accepted Cohort 2 practices in July. Complete.
Clinical Quality Measures reporting	x	x	x	x	x	x	x	x	x	x	X	x	x		On track.

Conduct Open Door Forum/Webinar for cohort 2					x										All activities for Cohort 2 were postponed by six months to account for the NCE and to avoid conflicting with CPC+. An in-depth explanation of the decision to delay is provided in the Health Care Service and Delivery section of the plan. Complete.
RFA for Practice cohort 2					x										
Practice cohort 2 selection						x									
Practice cohort 2 begins							x								
List of cohort-2 practices “in good standing” provided to payers.												x		x	The SIM office is working with members of the Multi-Payer Collaborative to determine the best process for sharing this list. The SIM office will share this list with payers by Dec. 31, 2018.
With stakeholder input, identify a patient experience of care measure.										x					Added since initial draft of AY3 plan. Delayed. The SIM team is still trying to collect data from practices. State led Evaluator, TriWest, is working with Medicaid CAHPS data and is trying to collect data from cohort 1 practices that confirmed that they would share their patient experience data for evaluation purposes.
Conduct Open Door Forum/Webinar for cohort 3									x						All activities for Cohort 3 were postponed by six months to align with the NCE. Complete.
RFA for Practice cohort 3									x						On track; the SIM office is working with partners at the University of Colorado to determine an exact timeline for Cohort 3 recruitment and implementation that will allow for sufficient time to close out the SIM cooperative agreement. Complete.
Practice cohort 3 selection										x					
Practice cohort 3 begins											x				
Small Grants to Primary Care Practices															
RFA for Practice Transformation Small Grants Released		x					x			x					Complete for Cohort 1 (47 awardees have received funds). Complete for Cohort 2 (38 awardees will receive funds). In progress for Cohort 3. The application for cohort-3 closed Aug. 17. Complete.
Funds distributed to awardees		x						x			x				
Awardees submit annual reports to SIM Office						x				x				x	New activity added since original operational plan.
Bi-Directional Health Homes															
Health Home Pilot Sites begin	x														Complete.
Health Homes Peer-Supported Learning Groups	x	x	x	x	x	x	x	x	x	x	x	x			On track.
Health homes patient enrollment and initial primary care visits		x	x	x											Complete.

Patient-specific and population-based data collection underway		x	x	x							x		x		On track.
Health Home sites fully operational and the model in full implementation							x	x	x	x	x	x			On track; previous delays due to release of funds.
Health Home Clinical Quality Metrics reporting							x	x	x	x	x	x	x		Began in year 3; currently on track.
CBHC conducts site visits to CMHCs	x	x	x	x	x	x	x	x	x	x	x	x	x	x	Ongoing. CBHC visits each site quarterly and the Program Implementation Manager went to the sites in November 2017.
CMHCs complete assessments and practice improvement plans with Practice Facilitator							x				x	x	x	x	On track.
CMHCs complete project plans outlining specific goals and next steps							x								Complete.
Health Home sites develop and submit final reports on all defined performance metrics, outcomes, cost savings, and lessons learned													x	x	On track.

Payment Reform ***Goal: By 2019, payers serving a majority of Coloradoans will reimburse practices for integrated physical health and behavioral health services in shared risk and savings programs***	**Year 2 (Feb. 2016 – Jan. 2017)**				**NCE (Feb. 2017 – Jul. 2017)**		**Year 3 (Aug. 2017 – Jul. 2018)**				**Year 4 (Aug. 2018 – Jul. 2019)**				**Changes, Short Description**
	Q1	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	
Payers sign Memorandum of Understanding with SIM Office	x														Complete.
Payers identify SIM practices they will support with alternative payment models (APMs), in conjunction with SIM office selection of initial cohort.		x				x			x						Complete.
Payers submit description of payment models that will be used to support SIM practices to the SIM office as an addendum to MOU.				x											Complete.
Engage in ongoing conversations with CMS regarding Medicare participation in the state in unique ways, in collaboration with its all-payer unit.	x	x	x	x	x	x	x	x	x	x					The SIM Office is still in communications with CMS. Medicare is not a participating payer in the SIM initiative; however, the SIM team launched an exploratory process into opportunities to engage with Medicare through an all-payer model.
Payers determine: 1) whether they can report attributed lives in practice based on four LAN framework categories; 2) whether they can report attributed lives in non-SIM participating practices.			x												Complete; final data collection template sent to payers in Oct 2016. After refining the evaluation questions near the end of 2017, the data collection template was simplified in January 2018. Some payers are struggling to provide this data in a timely manner.

Payers report on the following, annually: # of SIM practices in each APM category; # of attributed lives in SIM and statewide practices, by each APM category; percentage of payments to SIM and providers in each APM.						x				x				x	Delayed; updated annually; clarified data points; some payers have submitted CY2015 baseline data and the SIM Office is working with others to report baseline and year 1 2016 data. After refining the evaluation questions, the data collection template was simplified in January 2018. Payers are reviewing the template, the SIM office is offering technical assistance to help payers with this process, and in some cases, payers have begun to send data using this simplified data collection template. Most commercial payers will not be able to provide dollar amounts in terms of payments to providers but can provide percentage of payments to SIM providers in each LAN category out of the total payments to SIM providers. There are still significant barriers to collecting this data.
Determine expansion of RISE and Stratus tool licenses to practices participating in first SIM cohort.	x	x	x	x	x	x	x	x	x	x	x	x			Contracting delays with Best Doctors (the vendor for Stratus) extended this process. Cohort 1 practices are now on track to receive licenses by the end of NCE. Complete- cohort 1 sites have access to Stratus™ and will continue to have access through the end of 2018. The SIM office is working with Best Doctors and payers to address data quality issues and improve practice engagement with the tool. Cohort-2 sites will activate their license in May 2018 and cohort 3 once they are on boarded.
Continue outreach/engagement with self-insured employers, VA, and TRICARE.	x	x	x	x	x	x	x	x	x	x	x				On track re: self-insured plans (the SIM Office continues to make progress with the Colorado Business Group on Health) Delayed re: TRICARE and the VA (competing priorities with the Multi-Payer Collaborative have delayed this outreach. SIM is conducting outreach to the VA and TRICARE to determine next steps).
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	x	x	On track; conversations are ongoing. The SIM office is working to address issues related to eCQM reporting of alternative payment models.
Support ongoing dialog with state employee health plan administrators to expand/drive adoption of integrated care delivery and value-based payments.	x	x					x	x	x	x	x	x			Activity adjusted from original operational plan to reflect current goals.
Explore and assess opportunity to pursue an all payer model in Colorado, including global budgets for some rural hospitals and an APM opportunity for primary care providers.								x	x	x	x	x			Added item to note all payer opportunity work being conducted by SIM. As a part of this work, we are exploring the possibility of expanding access to APMs for primary care providers.

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				Complete.
Leveraging Regulatory Authority ***Goal: Use a range of legislative, regulatory, and policy levers to advance SIM goals and objectives and the achievement of the Triple Aim***	**Year 2 (Feb. 2016 – Jan. 2017)**				**NCE (Feb. 2017 – Jul. 2017)**		**Year 3 (Aug. 2017 – Jul. 2018)**				**Year 4 (Aug. 2018 – Jul. 2019)**				**Changes, Short Description**
	Q1	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	
Develop a sustainability plan to ensure successful implementation and impact beyond the term of the cooperative agreement							x	x	x	x	x	x			On track. Per guidance, final plan due December 2018.
Monitor policy barriers identified by SIM workgroups and analyze and recommend potential policy actions utilizing the SIM policy framework					x	x	x	x	x	x	x	x	x	x	On track (New activity added since original operational plan).
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	x	x	On track.
Work with state agencies and other organizations to coordinate/align legislative agendas	x	x	x	x	x	x	x	x	x	x	x	x	x	x	On track.
Work with state agencies to consolidate/streamline the fragmented oversight of physical, mental, and substance use providers and programs	x	x	x	x											Oversight has not been identified as a key priority, however the SIM Office will continue to align and coordinate between these providers and programs.
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	x	x	x	x	x	x	x			On track (timeframe extended to allow for continued consideration of alignment with CPC+ and Medicare Collaborative Care Models).
Clarify state and federal rules regarding information sharing between providers, specifically related to patient privacy and confidentiality and consent	x	x				x	x	x	x	x	x	x	x		On track
Use 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	x	x	On track.

Use policy levers to remove barriers and advance opportunities for alternative payment models	x	x	x	x	x	x	x	x	x	x	x	x	x	x	On track.
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			Delayed; The SIM Office is engaged in ongoing conversations with the DOI and DPA, but political uncertainties have hindered headway with these agencies.
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	x	x	On track (partnering with the Office of eHealth Innovation to create a statewide HIT roadmap, which will address this topic). The SIM Office anticipates that this roadmap will be available by the end of June and can be shared with CMMI at that point. Completed.
Monitor federal health IT policy, programs, and standards recommendations and disseminate state-wide	x	x	x	x	x	x	x	x	x	x	x	x	x	x	On track.
Evaluate telehealth regulations identifying potential barriers for widespread adoption - reimbursement, prescribing, and home monitoring	x	x	x	x	x	x	x								Completed in AY3.
Address scope of practice laws, credentialing and/or licensing to accommodate changing workforce							x	x	x	x					SIM Office has decided to narrow focus of this activity to supporting the behavioral health workforce. The SIM Office will work with the Office of Behavioral Health and Workforce Workgroup to address this topic.
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***	**Year 2 (Feb. 2016 – Jan. 2017)**				**NCE (Feb. 2017 – Jul. 2017)**		**Year 3 (Aug. 2017 – Jul. 2018)**				**Year 4 (Aug. 2018 – Jul. 2019)**				**Changes, Short Description**
	Q1	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**	**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	x	x			On track. Workgroup co-chair held symposium in November 2016 to address this topic. SIM Office will continue to disseminate findings and use them to inform strategy in AY3 and AY4.
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	x	x	On track (recommendations made on an ad hoc basis).

Develop resources for SIM-funded practices to support partnerships between primary care and behavioral health providers					x	x	x	x	x	x	x	x			On track. The workforce workgroup has prioritized this area of work, and will specifically give input on deliverables due from the Office of Behavioral Health (see Practice Transformation – Provider Education section). New activity added since original operational plan.
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***	**Year 2 (Feb. 2016 – Jan. 2017)**				**NCE (Feb. 2017 – Jul. 2017)**		**Year 3 (Aug. 2017 – Jul. 2018)**				**Year 4 (Aug. 2018 – Jul. 2019)**				**Changes, Short Description**
	Q1	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	
Telehealth															
Expand Broadband State-wide	x	x x	x	x	x	x	x	x	x	x	x	x	x	x	On Track.
Develop State-wide Strategy	x	x x	x	x	x	x	x	x	x						Extended the timeframe for developing the statewide strategy due to lack of sufficient information to release an RFP.
Use funding to implement telehealth/e-consult strategy							~~x~~				x				Delayed due to extension of statewide strategy development. Focus has shifted to align with Medicaid priorities and will now promote expansion of electronic consultations.
Implement Telehealth Strategy									~~x~~	~~x~~	~~x~~	~~x~~	x	x	Extensions of time frame to complete telehealth strategy pushed back implementation of the strategy accordingly.
Shared Practice Learning and Improvement Tool															
Training for Practice Transformation Organizations on use of SPLIT	x	x													Complete.
Initial use of SPLIT with first cohort practices		x													Complete.
Enhancement of SPLIT		x	x	x	x	x	x	x	x	x	x	x	x	x	The contact with IEQ has concluded and management and development of SPLIT has been transferred to the UCDFM staff. Further enhancements to SPLIT will be made by UCDFM staff.
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	x	x	
Quality Measurement Tool Development (QMRT)															

Vendor selected for design of short-term QMRT	x														Complete.
Short Term Solution operational		x													Complete.
CQM benchmark report to SIM cohort practice sites	x	x	x	x	x	x	x	x	x	x	x	x	x	x	On track; CQM benchmarking is provided to practices through static reports via SPLIT, not DartNet, after each quarter's CQM submissions. On track.
Quarterly collection of Clinic Quality Measures via QMRT		x	x	x	x	x	x	x	x	x	x	x	x	x	Continued use of QMRT will be in effect until development of QMRT+. During the NCE period, this function was transferred to Qualtrics. During AY4, this function will be transferred to SPLIT.
Data Acquisition and Aggregation with QMRT+															Based on work with HIT stakeholders the long-term QMRT+ may not be a central data hub, but rather a combination of solutions, that will address clinical quality measures and claims data. Work with contractor during NCE will inform what structure the solution(s) take. This topic is further addressed in the HIT narrative of this plan. QMRT+ is now called the SIM eCQM solution.
Develop and implement practice HIT assessment to understand data extraction and reporting, use of registries and HIE connectivity to inform the QMRT + solution							x	x	x	x	x	x	x	x	On track. (New activity since original operational plan).
Working with the Colorado data architect, develop Infrastructure Design Recommendation					x	x	x	x							Delays hiring a Data Architect resulted in delays in design recommendations. The SIM Office, in conjunction with the Office of E-Health, hired the Data Architect by the end of NCE and received initial design recommendations by Q1 of AY3.
RFP process for development of QMRT+							x	x	x	x					Delayed due to lack of Data Architect; SIM office working with vendor to write RFP – anticipated to be released during first two quarters of AY3. This refers to the eCQM solution, and the RFP was released. Due to the nature of this work an RFP was not used and instead a sole source was awarded to the SIM eCQM solution vendor.
QMRT+ Design and Implementation								x	x	x	x	x	x	x	Delayed due to lack of Data Architect and initial recommendations. This is the eCQM solution and the implementation work is on track.
Quarterly collection of Clinical Quality Measures via QMRT+										x	x	x	x	x	Delayed due to lack of QMRT+ development. QMRT will be used to collect CQMs until QMRT+ is available. SPLIT will continue to be the repository for CQMs for SIM. The SIM eCQM solution will be one way that is used to submit CQMs to SPLIT for SIM practices.

Program Monitoring and Reporting *Goal: Develop both process and outcomes measures to track progress toward the Triple Aim*	Year 2 (Feb. 2016 – Jan. 2017)				NCE (Feb. 2017 – Jul. 2017)		Year 3 (Aug. 2017 – Jul. 2018)				Year 4 (Aug. 2018 – Jul. 2019)				Changes, Short Description
	Q1	Q2	Q3	Q4	Q5	Q6	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Work with payer partners to support data aggregation across payers, including practice level reporting of cost and utilization data to inform care management and identify gaps in care							x	x	x	x	x	x	x	x	New activity added since original operational plan). See Payment Reform section for more details. This is a reference to Stratus™ and the work is on track.
Partners with Colorado Medicaid to maximize connectivity to state HIEs utilizing 90-10 matching dollars when available					x	x	x	x	x	x	x	x	x	x	On track. (New activity added since original operational plan).
All Payer Claims Database & Medicare Data (CIVHC)															
Quarterly APCD Data extracts for state-led evaluator and actuary		x	x	x	x	x	x	x	x	x	x	x	x	x	This was listed as "APCD data pull" in the original operational plan timeline. The team continues to experience issues with data quality and timeliness of these extracts. Delayed.
Annual APCD data extracts for federal evaluator		x					x				x				On track; extracts were originally scheduled for 3x per year; federal evaluation confirmed that they are only need once annually.
Establish, test, implement primary care attribution methodology	x	x	x												Complete; listed as "Attribution strategy identified" in original Ops Plan timeline, added clarity; delivered final attribution methodology in Sep 2016.
Bi-annual primary care attribution update			x	x		x	x		x		x		x		On track; CIVHC will run attribution for each new cohort and after each annual practice roster update with NPIs.
Establish, test, implement CMHC attribution methodology	x	x				x									Complete.
Bi-annual CMHC attribution update						x	x		x		x		x		On Track; ran bi-annually with methodology established to align with primary care schedule
Claims-based clinical quality measure proxy development and calculations				x		x		x				x			Development complete, reporting on track; delivered breast and colorectal cancer screening measures for CMMI and 2015 baseline proxy measure report in January 2017;

CIVHC annual work plan update					x		x				x				On track.
CIVHC monthly report	x	x	x	x	x	x	x	x	x	x	x	x	x	x	On track.
Medicare data extract for SIM data aggregation							~~x~~	~~x~~	~~x~~	~~x~~	x		x		Delayed; awaiting QE status achievement by CIVHC. Will only have two Medicare extracts in award year 4 as these extracts are done biannually.
Actuarial Reporting (Milliman)															
Quarterly aggregate SIM cohort cost & utilization reporting		x	x	x		x	x	x	x	x	x	x	x	x	Delayed. SIM office is updating with calendar year 2016 data in the final quarterly progress report of award year 3. The SIM office will continue to report these as data from the APCD is available.
Quarterly individual SIM practice site cost & utilization reporting		x	x	x		x	x	x	x	x	x	x	x	x	Delayed due to data issues. SIM office distributing to cohort 2 in September 2018 and to cohort-3 practices in late fall 2018.
Semi-annual Actuarial Cost & Utilization Reporting	x			x		x		x		x		x		x	Delayed due to issues around data.
APCD analysis reporting	x														Complete; ran analysis during year 1 and Y2Q1.
Pooling Reporting	x							x							Delayed; will resume if payers and stakeholders want to pursue common risk adjustment methodology.
Credibility Reporting	x							x							Delayed; will resume if payers and stakeholders want to pursue common risk adjustment methodology.
Member Attribution Logic Testing	x	x													Complete; CIVHC will run biannual attribution moving forward.
Risk Adjuster Model Reporting							x				x				Delayed; delivered preliminary report in year 1; will resume annual report if payers and stakeholders want to pursue common risk adjustment methodology.
Projected Cost & Utilization Report				x				x				x			On track; informs subsequent cost savings/ROI calculation.
Cost Savings/Avoidance & ROI Analyses Report						x				x				x	On track; first report June 2017.
MACRA report			x												Complete; ad hoc report to get landscape of practices participating in various APM initiatives.
Predictive Model Reporting	x			x			x				x				Delivered general report April 2016 and depression predictive model January 2017; will resume if payers and stakeholders want to pursue.
Payment Model Reform Reporting	x								x						Delayed; will resume if necessary data are available.

Creation and use of non-SIM practices as a comparison group in part of state led evaluation											x	x	x		Added since last submission. Comparison group of non-SIM practices matched to SIM practices on specific characteristics will allow for the evaluation of SIM's impacts on claims-based cost and utilization measures. Working with state-led evaluator.
Annual Summary Reporting	x								x				x		On track.
State-led Evaluation (TriWest)															
External Evaluation Vendor Contracted	x														Complete.
Initial work plan		x													Complete.
Revised evaluation framework		x													Complete.
Revised logic model		x													Complete.
Revised methodology		x													Complete.
Annual Data Analysis Plan			x				x				x				On track; delivered first report Y2Q3 and will update annually.
Initial central repository of measures		x													Complete.
Plan for capturing baseline data		x													Complete.
Initial establishment of baseline			x												Delivered draft; will update with full CY2015 APCD data.
Quarterly rapid-cycle feedback report			x	x	x	x	x	x	x	x	x				On track; listed as "quarterly report" in original operational plan timeline, added clarity; delivered report structure August 2016 and first Q3 rapid-cycle report October 2016.
Creation and use of non-SIM practices as a comparison group in part of state led evaluation											x	x	x		Added since last submission. Comparison group of non-SIM practices matched to SIM practices on specific characteristics will allow for the evaluation of SIM's impacts on claims-based cost and utilization measures. Working with actuarial partner.
State-led evaluator Annual report							x		x						Delivered August 2017.. Delayed. Update: August 2018, the SIM team is working with TriWest on this deliverable and will submit to CMMI for review once it's ready.
Draft sustainability plan							x								On track; delivered preliminary Aug 2017 and revise May 2019.
Final sustainability plan												x			On track; will deliver first quarter of 2019.

Final SIM evaluation report														x	On track; will deliver final evaluation report at end of grant period.
eCQM technical assistance (Mathematica)															
Data aggregation															
Stratus licenses for SIM cohort 1 practice sites, quarterly data refresh					x	x	x	x	x	x	x	x			On track cohort-1 will have access to data through Stratus until the end of 2018.
Re-procurement of data aggregation tool for SIM cohorts 2 and 3							x	x	x						Complete as of February 2018.
Quarterly data refreshes for SIM cohort practices.											x	x	x	x	Added since last submission. On track. Cohort 1 will have access to data through Stratus™ until the end of 2018. Cohort 2 and 3 will have access to quarterly data refreshes through June 2019.
CMMI Reporting															
Clinical quality measure reporting	x	x	x	x	x	x	x	x	x	x	x	x	x	x	On track.
Cost and utilization reporting						x	x	x	x	x	x	x	x	x	Delayed; waiting on full CY2015 baseline data from APCD; will deliver measures to CMMI in Y2Q1 report. Full CY 2015 baseline data was delivered. The SIM team is still experiencing delays with the APCD. We will report CY2016 data in the AY3 QPR.
Access to care reporting						x				x				x	Delayed; waiting on full CY2015 baseline data from APCD; will deliver measures to CMMI in Y2Q1 report. This is still delayed. The SIM team has CY 2015 baseline data; awaiting 2016 calculations and 2017 data from TriWest and CIVHC, respectively.
Population health reporting				x			x				x			x	On track; report annually as part of Q3 CMMI report.
Payer/payment model participation reporting						x				x				x	Delayed; working with payers to collect CY2015 baseline data and year-1 2016 data; will collect annually. After refining the evaluation questions, the data collection template was simplified January 2018. Payers are reviewing the template, the SIM office is offering technical assistance to help payers with this process, and in some cases, payers have begun to send data using this simplified data collection template. We continue to investigate alternative sources for collection, we have specifically begun discussions with Catalyst for Payment Reform. We continue to struggle with getting complete

															data consistently from every payer about their payment model information.
Model participation reporting (practice transformation, population health, HIT)	x	x	x	x	x	x	x	x	x	x	x	x	x	x	On track.

B. General SIM policy and operational areas

1. SIM Governance

a. Management structure

Governor's office engagement

The Colorado State Innovation Model (SIM) office was established by an executive order issued by Governor John Hickenlooper in March 2015. Since this time, the governor's office continues to play a crucial role in overseeing and providing guidance for implementation of the SIM initiative. While the Colorado Department of Health Care Policy and Financing (HCPF) serves as the fiscal administrator for SIM and employs SIM staff, the governor's office directly employs Barbara Martin, RN, MSN, ACNP-BC, MPH, SIM director. David Padrino, chief of staff to the lieutenant governor, and deputy chief operating officer, meets regularly with Barbara to provide guidance and leadership for the initiative.

The SIM office has an interagency agreement with the governor's office to evaluate the SIM director's performance, which ensures a direct line of sight into SIM progress. It also ensures an alignment of strategic goals and that SIM complements the state's broader health care agenda. For example, in September 2017, the governor's office contracted with Arrow Performance Group to assist with consumer engagement. This contract will run through July 2018, is managed by the SIM workforce and population health program manager and runs through the governor's office.

The SIM team works closely with the governor's office communications team to share updates, work on press releases and send social media suggestions. The governor visited a SIM pediatric practice in Colorado Springs last year, which was a wonderful opportunity to showcase the work the practice is doing and hear firsthand about how integrated care has improved the care provided to patients.

The governor appoints members of the SIM advisory board, which provides "advice, oversight, and guidance for 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."[1] Four of the 13 seats[2] are reserved for members of the governor's cabinet – the executive director of Colorado Department of Human Services (CDHS), executive director of the Colorado Department of Public Health and Environment (CDPHE), executive director of HCPF, and the commissioner of insurance. In Award Year 3 (Test Year 2) the SIM office worked with the governor's Office of Boards and Commissions to fill vacancies and to ensure the advisory board's ongoing success.

The SIM initiative is closely connected with the office of the lieutenant governor. Donna Lynne, DrPH, was sworn in as Colorado's 49th lieutenant governor and chief operating officer May 12, 2016. Prior to assuming her roles in Colorado state government, Dr. Lynne served as executive vice president of Kaiser Foundation Health Plan Inc. and Kaiser Foundation Hospitals, and as group president responsible for its Colorado, Pacific Northwest and Hawaii regions. Since taking office, Dr. Lynne has leveraged her expertise in the health care sector to offer crucial strategic guidance to the SIM team. In January 2017, Dr. Lynne participated in the inaugural SIM Multi-Stakeholder Symposium, which convened more than 80 representatives from SIM payers, practices, and practice transformation organizations, and presented during the All Stakeholder Convening in February 2018. She met with SIM payers to discuss key payment reform efforts and gain a better understanding of the MPC. Dr. Lynne is frequently quoted in SIM materials as she believes in the value of integrated care will continue to meet with SIM

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[1] Executive Order B 2015-001.

[1] 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.

payers and key stakeholders to ensure that SIM efforts are aligned with other payment reform efforts in the state.

Kyle Brown, the governor's senior health advisor, will continue to serve as co-chair of the SIM consumer engagement workgroup, sit on the steering committee, and act as a liaison between the governor's office and SIM. Barbara Martin, RN, MSN, ACNP-BC, MPH, SIM director, regularly participates in meetings of the governor's health care cabinet, which provide a crucial forum to create synergies between state agencies and health policy priorities including those outlined in the governor's State of Health report. Barbara will continue to participate in these meetings.

Multiple points of intersection ensure that Gov. Hickenlooper maintains a direct line of contact, communication, and input into the initiative, which acts as a natural convener of state agencies and other stakeholders to gain consensus and alignment around the state's health care priorities and goals.

b. Decision-making authority and stakeholder representation

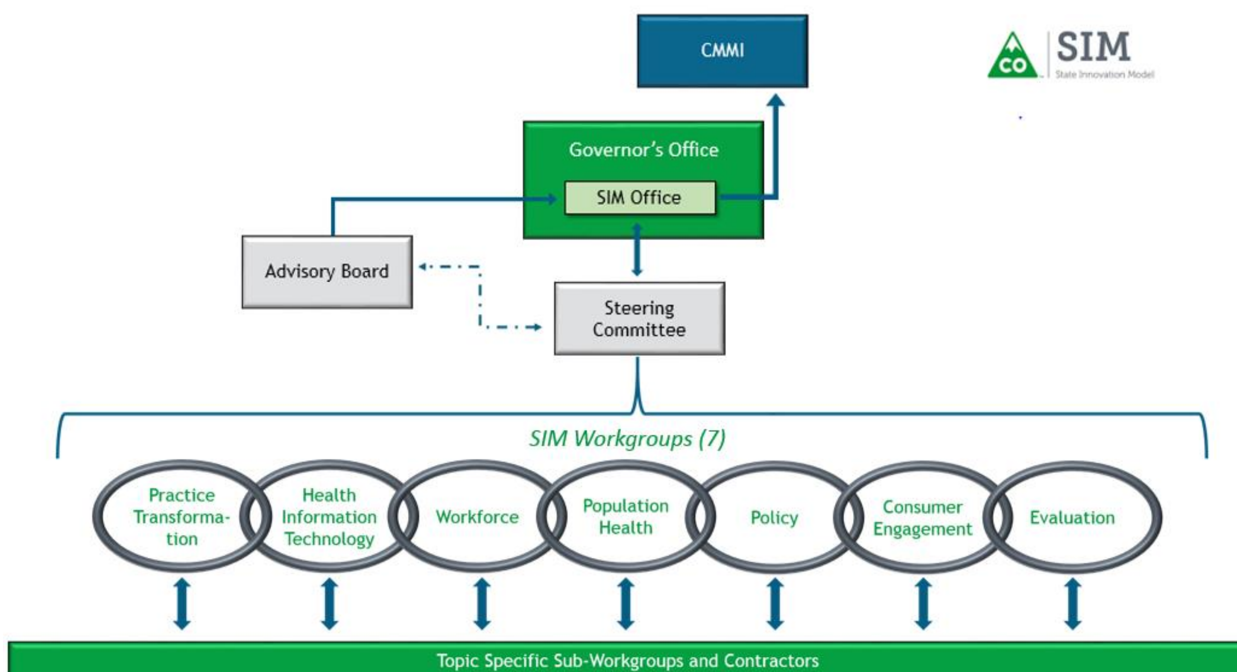
Executive authority

Governor John Hickenlooper signed **Executive Order B 2015-001** in March of 2015, creating the SIM office and establishing the SIM advisory board. Four of the 13 seats on the advisory board are reserved for members of the governor's cabinet (as outlined above.)

Governor Hickenlooper also signed **Executive Order B 2015-008** in October of 2015, creating the Office of Office of eHealth Innovation (OeHI) and the eHealth Commission. In executive order B 2015-008, OeHI is charged with collaborating with SIM to integrate physical and behavioral health, establish foundational HIT in support of value-based payment, and continue to further define priorities through the state's HIT roadmap efforts. The OeHI State Health IT Coordinator serves as a co-chair of the SIM HIT workgroup and advises SIM telehealth efforts.

SIM office

In AY4, The SIM office will continue operating under the following governance structure, which was designed to engage stakeholders, create avenues for constituent groups that implement the objectives of the program to provide input and sustain a collaborative environment for the initiative:



The SIM office oversees the initiative and is responsible for coordinating efforts with other state agencies including HCPF, CDHS, CDPHE, the Colorado Department of Regulatory Agencies (DORA), and The Department of Personnel and Administration (DPA); consulting with all relevant stakeholders including representatives from public, private, and nonprofit health care sectors; and facilitating and coordinating communications between state departments, external stakeholders, and the Centers for Medicare & Medicaid Services (CMS). SIM office roles and responsibilities include:

- Coordinating with CMS, the Office of the National Coordinator (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 fulfill the work outlined above.

In AY4, the SIM office will continue to oversee and support stakeholder workgroups, the steering committee and the advisory board. Each workgroup has an assigned SIM office staff member, who is responsible for the following: 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, SIM office staff works to ensure that stakeholders engaged at each level of the governance structure have the resources and support needed to successfully meet their defined goals and objectives so the SIM initiative can advance in a timely and efficient manner.

Workgroups

SIM workgroups continue to form the core of the SIM governance structure. The workgroups are designed to provide a forum for stimulating ideas and discussions on how to advance SIM's goals and objectives. Workgroup members are tasked with identifying specific activities and/or action items, and making recommendations to the SIM office, which shares the information with the steering committee and updates the advisory board regularly. The SIM office, as the sponsoring authority for the SIM initiative, holds ultimate decision-making authority, and is responsible for executing recommendations made by any entity within the governance structure. Each workgroup continues to be led by two or three co-chairs and supported by a program manager from the SIM office. (Please see the stakeholder engagement section for a detailed description of the workgroups and their charters.)

The SIM office hosted a special meeting of the steering committee in AY3 to reassess work and ensure that all workgroups had a clear understanding of how their efforts map to SIM goals. It was an effective day that reenergized stakeholders and prepared workgroup members for the All Stakeholder Convening that was held in February 2018. Work to ensure that all stakeholders are collaborating across workgroups to accomplish their goals and lay the groundwork for sustainability will continue in AY4.

The SIM initiative has achieved a high-level of retention for workgroup members and enters AY4 with very few vacancies. Workgroups have been active in AY3 and the SIM office anticipates robust activity in AY4. Workgroups spent time in AY3 reevaluating how their work supports SIM goals and setting short-term goals. In AY4 they will work on meeting those short-term goals, which align with the larger SIM goals.

Repurposing of the payment reform workgroup

As noted in the last operational plan, the SIM office reassigned members of this workgroup to ensure that subject matter expertise was sprinkled across the seven other workgroups so they could provide input on payment reform. The team also started multi-stakeholder symposiums that convene payers, practices and practice transformation organizations (see the stakeholder engagement section for more information) to jumpstart more effective

conversations about how SIM helps providers succeed in APMs. With these meetings, which happen three times a year, and bimonthly meetings of the MPC (See payment and service delivery models section for more information), stakeholders agreed that there were ample opportunities to discuss payment reform strategies and issues in forums that supported SIM's mission. This has proven to be a successful move. The co-chairs continue to participate in steering committee meetings to ensure that a payment reform perspective is still represented on that group and have been involved in the multi-stakeholder symposiums as well.

Steering committee

This group is made up of the co-chairs of each workgroup, and is charged with:

- Reconciling issues and timeline dependencies identified 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 committee is intended to coordinate activities across SIM workgroups, which reflect each of the model's key components. The steering committee is tasked with identifying key dependencies between workgroups and ensuring they are moving forward in a coordinated and complementary fashion. In addition to discussions on cross-cutting issues, this committee serves as a forum to address topics that cannot be resolved at a workgroup level. It can also refer difficult issues to the advisory board for further guidance and recommendations. The steering committee will continue to meet every month in AY4.

SIM advisory board

This group provides oversight and guidance for the operation of the SIM office and management of SIM grant funds and will continue to meet every other month in AY4. Members are appointed by the governor to serve four-year terms. As initially outlined in the March 2015 executive order, the board had nine positions:

- The director of the SIM office, 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 Health Information Technology (HIT);
- The executive director of HCPF, or his or her designee;
- The executive director of the CDHS, or his or her designee;
- The executive director of CDPHE or his or her designee; and
- The Commissioner of Insurance, or his or her designee.

The board added the following four positions in November 2015:

- A representative of a statewide health insurance carrier;
- A representative of the statewide association of hospitals; and
- Two representatives of consumer interests.

A list of current advisory board members is attached as ***Appendix D1.***

Quality assurance committee

The University of Colorado Department of Family Medicine convened a Quality Assurance Committee to review practice and practice transformation organization (PTO) progress. While not convened by the SIM office, this committee provides critical recommendations to the SIM office on quality assurance processes and a crucial

avenue for ensuring sufficient achievement in practice transformation. As more data is submitted, this group will continue to discuss traits of successful practices, barriers to implementation, and corrective action required for SIM practices and PTOs that are not meeting defined requirements. A roster of committee members is included as ***Appendix D2.***

Statewide health plan representation:

Seven public and private payers that signed a Memorandum of Understanding (MOU) with the SIM office in February 2015 and agreed to work collaboratively with SIM to transform the way physical and behavioral health care are delivered and financially supported in SIM continue to be involved in the Multi-Payer Collaborative (MPC), which is outlined in greater detail later in the report. These payers include:

- Anthem Blue Cross Blue Shield
- Cigna
- Colorado Choice Health Plans
- Health First Colorado (Medicaid)
- Kaiser Permanente
- Rocky Mountain Health Plans
- UnitedHealth care

In June 2017, Friday Health Plans acquired Colorado Choice Health Plans. Due to this acquisition, Colorado Choice Health Plans is no longer participating in the MPC. As a result, there are now six payers in the MPC.

These payers will continue to collaborate in AY4 on the following:

- Focus on primary care practice sites and behavioral health settings seeking to integrate care;
- Support providers in delivering and coordinating integrated care that improves population health, and increases quality while reducing costs;
- Increase providers' abilities to manage whole-person care;
- Develop necessary infrastructure to support integration and delivery of whole-person care; and
- Encourage practice sites to continually evolve towards higher-levels of integration through transformation of care delivery support by alternative payment models (APMs).

These payers come together during monthly meetings of the MPC, a self-funded, self-governing entity voluntarily formed by payers to develop organizational alignment and consistency around the support of SIM as well as the Comprehensive Primary Care Plus (CPC+) initiative. While a more comprehensive picture of SIM's work with the MPC is detailed in the payment and service delivery models section of this plan, Colorado's ongoing engagement of payers represents a crucial strategy for coordinating private and public efforts around key test model components. The MPC will continue to meet on a bimonthly basis in AY4 and beyond.

In AY4, SIM will continue to conduct broad outreach to the state's largest payers and engage self-funded employers to drive demand for integrated behavioral health in the administrative service organization/third-party administrator market.

In AY3, the SIM team worked with payers to establish a "good standing" approach for practice sites in cohorts 2 and 3 to help illustrate the work practices accomplish in SIM and to help payers understand what it takes to integrate care and succeed in APMs. Practice "good standing" is achieved by successfully completing identified building blocks and achievement of key milestones in the SIM Framework. If practice sites are not in good standing, payers will determine how that affects their programs and payment. In AY4, the SIM office will continue to work with PTOs and UCDFM to support transformation and to determine a practice site's standing. This information will be shared annually with payers. More information about "good standing" is shared in the

payment and service deliver models section.

Programmatic, financial and communications oversight

HCPF is the designated fiscal agent for SIM Model Test award. All vendor contracts to implement the SIM model must go through the Colorado Department of Health Care Policy & Financing (HCPF) 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 HCPF. Contracts for SIM-related work are primarily deliverable-based and contain a detailed description of a vendor's responsibilities for implementation of specific program components, costs/finances for activities, and expectations regarding ongoing communication with the SIM office. As sponsoring authority for the SIM initiative, the SIM office maintains ultimate responsibility for the execution and monitoring of all vendor contracts and ensuring successful and timely completion of all project deliverables.

The SIM office will continue to coordinate implementation activities across key program areas with state agencies involved in the administration or regulation of Colorado's health care system, including HCPF, 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.

Coordination of private and public efforts

The SIM office will continue to 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 workgroups, the steering committee and advisory board. Examples of private efforts with which the SIM office collaborates are outlined by primary driver below. Additional information about public-private partnerships is sprinkled throughout the sections, including the practice transformation section below.

2. SIM operational areas

a. Practice transformation

The SIM team intended to work with approximately 400 practices in the three planned cohorts. Each cohort provides direct practice intervention to teach and support integration through regular practice meetings with practice facilitators and CHITAs. This model has been successful. However, the number of applications for cohort 3 did not make it possible to reach the 400-mark through SIM cohort practices. With that in mind, the SIM team will take a broader look at how SIM influences practice transformation efforts in Colorado in AY4, and look beyond the cohorts to include other practices touched by regional health connectors and local public health agencies. Other work will include outreach to Indian Health Services, Veterans Affairs and school-based health clinics that are not participating in the cohorts.

Part of the SIM practice transformation package includes access to a competitive small grants process. The SIM office was awarded a $3 million grant from The Colorado Health Foundation to provide SIM primary care practices with competitive small grants to advance behavioral health integration. To date, the SIM office has made awards to 87 practices in cohorts 1 and 2. The funding stream for these small grants changed for cohort 2 as outlined in the practice transformation in primary care setting section. The team will continue to work with practices that apply for grants from The Colorado Health Foundation and make new awards in AY4. The SIM program implementation manager and SIM small grants administrator meet regularly with The Colorado Health Foundation representatives to ensure that the evolution of the small grants program aligns with the strategic goals of both organizations. Staff from The Colorado Health Foundation have attended practice transformation workgroup meetings and receive regular rapid-cycle feedback reports on the SIM initiative. Key leaders from the SIM office and the foundation jointly make decisions regarding use of these funds.

The SIM office remains in close contact with other foundation partners via the Early Childhood Mental Health Funders network. SIM has met with a group of funders (The Colorado Health Foundation, Rose Community Foundation, Aloha Foundation and Community First Foundation) to discuss how SIM could advise the group, which seeks to provide enhanced support to pediatric practices.

SIM team members will continue to attend monthly meetings of this group to ensure the initiative is aligned with other state efforts. Throughout AY4, the SIM director will work with this group to identify potential avenues for public-private partnership. See more detail in the practice transformation in primary care setting section.

b. Payment reform

Seven public and private payers signed a Memorandum of Understanding (MOU) with the SIM office indicating their commitment to working collaboratively with SIM to transform the way physical and behavioral health care are delivered and financially supported in the practice sites selected for SIM within these networks. While a more comprehensive picture of SIM's work with the MPC is detailed in the payment and service delivery models section, Colorado's ongoing engagement of payers via the MPC, as outlined in the MOU, represents a crucial strategy for coordinating private and public efforts around key test model components. The MPC, which now has six active payers as explained earlier in the document, will continue to meet on a bimonthly basis in AY4.

While each payer uses its own payment model to support SIM's transformation goals, the payment model(s) include the following basic elements:

1. Fee-for-service payments;
2. Payments that include behavioral health integration through one of the following mechanisms:
   a. Upfront payments;
   b. Population-based payments (e.g., PMPM);
   c. Care coordination payments; or
   d. Payment for additional codes.
3. Shared savings opportunities OR incentive payments based on performance and/or outcomes linked to quality.

The payment models used by each payer are outlined on the SIM website under "payment support," and align with the HCPLAN framework. Each payment model includes one or more of the following components:

- A per member per month for population health management activities with a shared savings opportunity;
- A per member per month with shared savings opportunity linked to population management or an episode of care;
- An Accountable Care Collaborative Behavioral Health Integration Program, which includes quality /incentive payments over a managed fee-for-service system;
- Fee-for-service linked to quality and value, and population-based payments; and
- Enhanced fee-fee-service with shared savings and upside arrangements, population-based payments, and enhanced global payments.

For more information, please see ***Appendix D3***_CO SIM for a description of what each payer's payment model entails.

Outreach to payers to gather more information about their APMs will continue in AY4. In AY3 the team developed a new template to collect this information in a more efficient manner.

The SIM team will continue to encourage payers to send more communication to SIM practices about what their APMs entail as we continue to hear confusion about how payers are supporting practices through SIM and some

practices do not realize that they are participating in an APM. The SIM team will continue to encourage more dialogue between health plan and practice representatives to ensure future success with APMs after the initiative ends.

The SIM team continues to work with the Colorado Business Group on Health, which recently signed a new agreement with the APCD and will be submitting data to that database. In AY4, the team will continue to monitor discussions between self-insured plans and CIVHC, as this is related to SIM efforts.

c. Population health

Establishing a strong and ongoing partnership between Colorado's public health system and the behavioral health and primary care sectors remains crucial to SIM's efforts to address factors outside the clinical setting – including social, economic, and environmental influences – that influence patient health. The plan for improving population health section of the operational plan outlines how the Colorado Department of Public Health and Environment (CDPHE) and the Colorado Health Institute (CHI) continue to lead population health efforts via local public health agencies (LPHAs), Behavioral Health Transformation Collaboratives (BHTCs) and the Regional Health Connectors (RHCs)

In AY3, CDPHE contracted with Health Management Associates (HMA) to conduct an environmental scan and gap analysis of behavioral health initiatives by public and private sectors in Colorado. SIM then contracted with HMA to use the scan to inform a Call to Action (CTA). Key stakeholders, including the population health workgroup, were instrumental in the design and creation of the report. This CTA will be used in AY4 to drive population health workgroup activities and shape behavioral health improvement in Colorado during the next 15 years.

d. Health information technology (HIT)

A central component of 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 a statewide reach, public and private collaboration remains essential to achieving the goals.

Office of eHealth Innovation

The SIM team will continue to work closely with the Office of eHealth Innovation (OeHI), housed within the governor's office, in AY4. The office will continue to play an important role in strengthening public-private collaboration around HIT initiatives in the state. Public and private collaboration and coordination will figure prominently in several SIM HIT initiatives, including:

- Data Acquisition, Aggregation, & Integration – In AY4, SIM will continue 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 to assess the initiative's integrative efforts and ability to produce predictive analysis. All laws and rules regarding patient privacy will be followed;

- Analytical Reporting – Data extraction, analysis and reporting capabilities 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.

3. Policy

a. Integration/alignment with existing legislative and executive authority

SIM is well aligned with executive and legislative authority. The SIM office was formed with an executive order, and there is statewide support for the work SIM is doing through the legislative branch.

b. Legislative authority

The SIM office is aware of and in alignment with state legislation that sets the stage for successful health care integration in Colorado. Key legislation enacted since the inception of SIM was included in the original operational plan. Since that time, the SIM office is attempting to align with the bills outlined below, if possible. In AY4, the SIM Strategy and Policy Manager will continue to scan and identify bills and ways in which legislative authority can help sustain SIM's progress and goals beyond the initiative.

c. 2017 legislative update:

HB17-1094 - Telehealth Coverage Under Health Benefit Plans – Clarifies telehealth parity with traditional (in person) services. Legislation passed in 2015 went into effect Jan. 1 and this bill provides context.

HB17-1173 - Health care Providers and Carriers Contracts – protects health providers when they disagree with, report, or participate in investigations of carriers. These protections are to be explicitly stated in contracts between carriers and providers.

SB17-065 - Transparency in Direct Pay Health Care Prices - Requires health care professionals and facilities to publish prices for directly-billed services. The act also prohibits penalties for anyone participating in direct-pay services. (Went into effect Jan. 1, 2018)

SB17-074 - Create Medication-assisted Treatment Pilot Program - creates the medication-assisted treatment (MAT) expansion pilot program, administered by the University of Colorado College of Nursing, to expand access to medication-assisted treatment to opioid-dependent patients in Pueblo and Routt counties. The pilot program will provide grants to community- and office-based practices, behavioral health organizations, and substance abuse treatment organizations.

HB17-1353 - Implement Medicaid Delivery & Payment Initiatives - Authorizes HCPF to continue its implementation of the accountable care collaborative (ACC). The bill defines the goals of the ACC and the department's implementation of the ACC, including, in part, establishing primary care medical homes for Medicaid clients, providing regional coordination and accountability, and integrating physical and behavioral health care delivery. The medical services board is required to promulgate rules implementing the ACC.

SB17-193 - Research Center Prevention Substance Abuse Addiction - The bill establishes the center for research into substance use disorder prevention, treatment, and recovery support strategies at the University of Colorado Health Sciences Center.

SB-019 - Medication Mental Illness in Justice Systems - The bill implements recommendations from the task force concerning the treatment of persons with mental health disorders in the criminal and juvenile justice systems and the medication consistency work group of the behavioral health transformation council to promote increased

medication consistency for persons with mental health disorders in the criminal and juvenile justice systems.

SB-300- High-risk Health Care Coverage Program - Concerning the authority of the commissioner of insurance to implement programs to address the rising costs of providing health care coverage to high-risk individuals in the state, and, in connection therewith, directing the commissioner to study issues related to the implementation of such programs.

HB17-1351 - Study Inpatient Substance Use Disorder Treatment - The bill requires the department of health care policy and financing, with assistance from the department of human services' office of behavioral health, to prepare a written report for committees of the general assembly relating to residential and inpatient substance use disorder treatment options under the Medicaid program, the cost of treatment, and the potential impact on other state and county programs and services if residential and inpatient substance use disorder treatment options were effective.

SB-146 - Access to Prescription Drug Monitoring Program - The bill modifies provisions relating to licensed health professionals' access to the electronic prescription drug monitoring program to allow health care providers who prescribe controlled substances to query a patient regardless if they are that patients' prescriber or not.

d. 2018 Legislative progress (bills signed into law as of April 2, 2018):

SB18-020 - Registered Psychotherapists Auricular Acudetox - The bill allows registered psychotherapists, mental health professionals and level three addiction counselors who have documented that they have obtained training requirements to perform auricular acudetox.
HB18-1086 - Community College Bachelor Science Degree Nursing - allows a community college that is part of the state system of community and technical colleges to offer a Bachelor of Science degree in nursing as a completion degree (nursing degree).
HB18-1032 - Access Medical Records State Emergency Medical Services Patient Care Database - Requires the CDPHE to provide individualized patient information from the department's EMS agency patient care database to health information exchanges for any use allowed under HIPAA.

e. Opioid Interim Committee legislation

During the summer of 2017 an opioid interim study committee was formed to study and identify legislative solutions to combat the growing opioid crisis in Colorado. Given SIM's goal of expanding access to behavioral health services and combating substance use disorders, our team continues to monitor these six bills. As of April 2nd, all six bills were under consideration in various committees.

SB18-024 Expand Access Behavioral Health Care Providers - Modifies the Colorado health services corps to address shortage areas for behavioral health care providers. This bill allows participation in the loan repayment program on the condition of committing to provide behavioral health care services in health professional shortage areas for a specified period. Also establishes a scholarship program to help defray the costs of addiction counselor training.

HB18-1003 Opioid Misuse Prevention - Establishes a committee (of legislators) to study prevention, harm reduction, and treatment of opioid addition. The bill will expand funding for behavioral treatment through grant applications and identify legislative options for future sessions.

HB18-1007 Substance Use Disorder Payment and Coverage - Requires all health benefit plans to provide coverage without prior authorization for a five-day supply of medication (buprenorphine) used to treat opioid addiction. The bill also prohibits carriers from requiring a covered person to undergo step therapy using a prescription drug

or drugs that include an opioid before covering a non-opioid prescription drug recommended by the covered person's provider.

HB18-1136 Substance Use Disorder Treatment - Adds residential and inpatient substance use disorder services to the Colorado Medicaid program.

SB18-022 Clinical Practice for Opioid Prescribing - Restricts the number of opioid pills that a health care practitioner may prescribe for an initial prescription to a 7-day supply and one refill for a 7-day supply, with certain exceptions.

SB18-168 Medication-assisted Treatment Through Pharmacies - Requires extended-release opioid antagonists for use in medication-assisted treatment to be included as a pharmacy benefit under the medical assistance program.

4. Roles and responsibilities of staff and contractors

a. SIM office

SIM director

Barbara Martin, RN, MSN, ACNP-BC, MPH, accepted the role of interim director in March 26 and was promoted to the role of director in September 2016. She has more than 15 years of clinical and leadership experience in health care delivery, care coordination, and working across complex systems of care. She received a master's degree in public health with a focus on population-based policy and systems change work to enhance and improve systems of care delivery in 2013.

Ms. Martin has been engaged with the SIM initiative since 2013. As director of the Health Systems Unit at CDPHE, she served on the core SIM team during the grant planning process and led state public health efforts to implement population health strategies to support SIM.

She joined the SIM office in 2015 as director of the Transforming Clinical Practices initiative (TCPi) to lead statewide efforts to build a program that helps clinicians and practices transition into new care delivery and payment models.

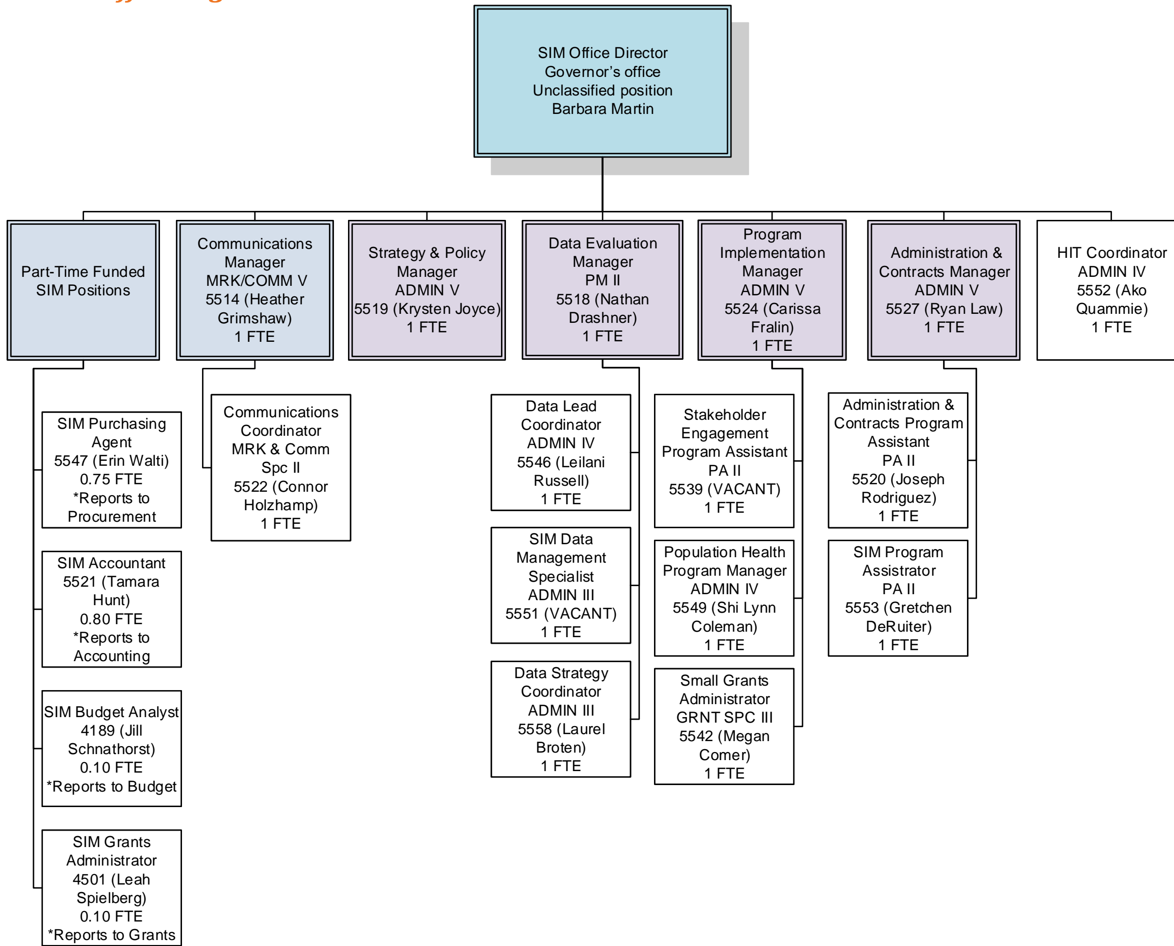
SIM staff

The roles and responsibilities for all SIM office staff (full-time, temporary and contract) are outlined below. As part of the onboarding and orientation process, staff members have one-on-one meetings with the SIM office director and management staff to whom they report directly, to review and clarify job responsibilities and expectations. Those responsibilities are outlined in the chart below and in state-required position descriptions maintained by the HCPF's Human Resources department and the state's human resources department.

The SIM office employs 15 full-time (1.0 FTE) positions. In the past year, the office has created one new staff (1.0 FTE) position and hired employees to meet needs identified during AY3 and AY4. The changes during AY3 include:

- Two positions were vacated and will be filled by June 2018.
- The newly created position was to maintain the telehealth workload as well as support the data team and was filled by a temporary employee.
- Five partial FTE positions (noted in the organizational chart as well as in the Delineated Roles in Responsibilities chart below).
- There are no temporary positions (hourly) but that might change due to work influx during AY4.

The SIM office organizational chart:



A list of current SIM staff members is attached as ***Appendix D4.***

All SIM positions will ensure support in the following areas throughout AY4. Descriptions:

Delineated Roles and Responsibilities for Full-time Staff	
Roles for Existing Staff	**Responsibilities**
SIM Director	Oversees the coordination and administration of all aspects of SIM including planning, organizing, staffing, leading, and guiding activities. Ensures implementation and achievement of all planned initiative activities and essential goals. Develops relationships with and creates boards and committees that comprise stakeholders, advisors, health care organizations, state and federal agencies as well as representatives from the governor's office that effectively steer the initiative and help achieve desired outcomes. Determines needs for external vendors to assist with implementation and auditing of the SIM initiative. Represents SIM and publicly communicates goals and opportunities. Holds signing and appointing authority for the office and is accountable for all initiative outcomes. Reports directly to governor's office.
Program Implementation Manager (Formerly SIM Operations Manager)	Oversees implementation of SIM initiative activities. Manages relationships with and between staff and partners, including stakeholders, SIM boards and committees, advisors, workgroup leaders and other entities and individuals who support implementation of the initiative (initiative partners). Manages processes and workflow of the SIM office as they relate to progress of initiative implementation. Oversees development and implementation of a comprehensive shared knowledge database for all initiative partners. Presents on initiative progress to the SIM office, initiative partners and public audiences. Publicly communicates the goals and opportunities offered by SIM. Manages multiple SIM office vendor contracts. Manages the population health and workforce program

	manager, the stakeholder engagement assistant and the small grants administrator. Reports directly to the SIM director.
Strategy and Policy Manager	Develops and maintains expertise on health care policy issues related to the SIM initiative, stays abreast of substantive literature and ongoing political and policy developments. Participates in policy-relevant research, analysis and advice on complex policy and regulatory issues in health care focusing on policy and regulatory issues that pertain to the integration of physical and behavioral health, data sharing, collection, aggregation, and reporting, and HIT. Analyzes policy and regulatory issues associated with state agencies involved with SIM as well as their federal counterparts. Develops reports, policy documents and other written materials for a wide range of audiences and purposes. Presents to the SIM office, program partners and public audiences. Builds an effective and credible government affairs strategy that identifies and meets the needs of the initiative. Reports directly to the SIM director.
Administration and Contracts Manager	Oversees administrative functions of the SIM initiative. Manages continual improvement process for SIM office projects, operations and workflows with the goal of maximum efficiency. Oversees procurement, contract management, and performance for the SIM office. Manages contractual budgets to ensure appropriate expenditures within allocations, identifies additional fiscal needs and prepares appropriate budget requests. Works with appropriate state and federal governmental offices to obtain necessary contract and budget approvals. Manages the SIM program assistant and contracts manager program assistant and reports directly to the SIM Director.
Population Health and Workforce Program Manager	Manages workforce, population health and consumer engagement stakeholder workgroups and sub-workgroups. Serves as workgroup liaison between the SIM office and stakeholders working on physical and behavioral health integration. Partners with health care organizations to build, strengthen, and coordinate efforts in the health care community. Manages multiple SIM office vendor contracts. Designs strategy, systems, processes, guidelines, rules, and standards that are mission critical and directly affect SIM's operation and policy. Reports directly to the program implementation manager.
Stakeholder Engagement Program Assistant (Vacant)	Responsible for scheduling SIM office events between staff and stakeholders. Maintains the HCPF calendar as well as the SIM office calendar to ensure that rooms, necessary equipment, and supplies are available for workgroup, advisory board and steering committee meetings. Works closely with SIM office program managers assigned to each workgroup to ensure appropriate content, communication presentation and documentation of all SIM workgroup meetings. Reports directly to the SIM program implementation manager.
Administration and Contracts Program Assistant	Acts as liaison with SIM contract managers, HCPF procurement and accounting departments. Maintains tracking and archival systems for all SIM office contracts, deliverables and invoices and contract amendments. Manages operating expenditures, such as office supplies. Reports directly to the SIM administration and contracts manager.
Communications Coordinator	Provides technical and content development assistance for the public SIM office website. Maintains SIM office SharePoint site, provides design and technical assistance for SIM board and committee meetings and presentations. Performs ad-hoc writing and editing assignments. Reports to SIM communications director.
Small Grants Administrator	Manages the SIM small grants program. This salary is funded by a grant from the Colorado Health Foundation. Reports directly to the SIM program implementation manager.
HIT Coordinator	Manages and coordinates the HIT initiative by working with OIT, the OeHI, SIM office, the OBH and HCPF to coordinate the overall outcome of HIT, eCQM and Telehealth. Also manages the HIT workgroup and sub-workgroup meetings as needed. Serves as workgroup liaison between the SIM office, the Office of eHealth commission and stakeholders working to integrate physical and behavioral data. Manages multiple SIM HIT vendor contracts. Takes actions and issues expert opinions that provide direction for future action by others. Designs strategies, systems, processes, guidelines, rules, and standards that bring SIM closer to meeting its HIT goals. This work must integrate OIT's statewide architecture and align with OeHI's future vision for HIT in Colorado. Reports directly to the SIM director.
Data Evaluation Manager (formerly SIM Evaluation Specialist)	Oversee and Manage SIM Data Partners, governor reports, data contracts, as well as SIM data evaluation and sustainability efforts. Manages health care organizations to build, strengthen, and coordinate efforts in the health care community through effective exchange of clinical and claims data. Works with external evaluation contractor and external data contractors to analyze the metrics of SIM performance for multiple key performance indicators. Acts as a liaison between various SIM office workgroups and employees to establish clear metrics for reporting. Presents to SIM workgroups boards and committees. Manages the data lead coordinator, data strategy coordinator as well as the SIM data management specialist. Reports directly to the SIM director.

Data Lead Coordinator	Researches, reviews, cross-references, and compiles reports from multiple data streams as they relate to the functions of SIM. Identify available data resources and gaps in current data, coordinate and/or assist in the development of mechanisms for data collection and reporting, perform advanced dataset manipulation functions (aggregation, normalization), conduct ongoing data quality monitoring, develop presentation of data for end users, act as a direct resource for questions and identifying trends, and coordinate with internal and external evaluators for SIM- related data pools. Provide accurate and timely analysis of policy and programmatic topics that affect the SIM initiative with a focus on practice transformation, payment reform, data sharing, governance and HIT. Reports directly to the Data Evaluation Manager.
SIM Data Management Specialist (formerly SIM Policy & Data Analyst-vacant)	Works closely with the SIM data team. Researches, reviews, cross-references, and compiles reports from multiple data streams relating to SIM. Helps develop and improve data collection and reporting mechanisms. Presents reports to SIM office workgroups, manages SIM vendor contracts and reports directly to the SIM data and evaluation manager.
Data Strategy Coordinator	The Data Strategy Coordinator will work on the Telehealth data solution, which requires collaboration with stakeholders, including the OIT, the OeHI, SIM office, and HCPF. This involves meeting with stakeholders, researching and developing architecture, and presenting to business executives. Work will include defining technical requirements and HIT architecture, developing data models, and overseeing the implementation and sustainment of this solution.
SIM Program Administrator	This position is responsible for the lead administrative duties of the SIM office including scheduling, staffing, office planning and organization, as well as working with the SIM Administration and Contracts Manager on the budgetary needs of the SIM office. This position will work closely with HCPF HR for the authoring and posting of all SIM on-boarding and termination requirements. In addition, this position will provide project management for the SIM office by tracking project progress across work categories. Responsible for scheduling SIM office events between staff, governor's office and CMMI. Coordinates office deliverables for CMMI, the governor's office as well as HCPF. Reports directly to the SIM administration and contracts manager.

Delineated Roles and Responsibilities for Existing Partial FTE Staff	
Roles for Existing Staff	**Responsibilities**
Communications Manager (0.7 FTE) SIM, .3 FTE TCPI)	Manages internal and external communications for SIM including managing media relations, improving and managing external stakeholder communications, managing SIM-related meetings and conferences, and creating communications materials in conjunction with the Governor's Office and HCPF staff and other program partners. Provides management and oversight of the SIM external website, newsletters and other public communications. Manages communications coordinator and reports directly to the SIM director.
Accounting Technician (0.8 FTE)	Works closely with the administration and contracts manager and program assistant. Maintains the accounting set-up for the SIM initiative and other SIM program funding sources. Creates accounting reports and ensures that Grant Solutions has been updated to reflect SIM office expenditures in a timely manner. Reports directly to the HCPF Accounting department.
Purchasing Agent (0.5 FTE)	Works closely with the administration and contracts program manager and other SIM staff managing contracts and purchase orders. Prepares purchasing documents, solicitations and contracts issued by the department. Maintains compliance with state/federal laws, rules, and contracting standards to ensure that contracts protect the interests of the department, the SIM office and the federal government. Reports directly to the HCPF Purchasing and Contracts Department.
Grants Administrator (0.1 FTE - Vacant)	Oversees the SIM initiative. Will be trained by the SIM administration and contracts manager. Uses the federal grants management portal, Grant Solutions, for SIM purposes. Assists the SIM team with the writing and submission of grant applications, troubleshooting grant issues during implementation and writing and submitting grant reports. Reports directly to the HCPF Grants department.
Budget Analyst (0.1 FTE)	Develops a tracking methodology for the grant award and includes accounting coding, the approved budget, expenditure tracking and other relevant information. Works closely with grant staff to ensure that the budget is not overspent and that there is a mutual understanding of when funds are to be spent. Responsible for reviewing clearance items (contracts, budget submittals, and expenses reports). Works with program and grant staff to develop budget tables and summary documentation for new grant applications. Ensures that calculations are accurate, timely and reflect the needs of the program. Remains updated on the progress of grant implementation once approval is received and provides budget support as needed to implement the initiative. Reports directly to the administration and contracts manager.

External contractors

The roles and responsibilities of the vendors/contractors retained to support SIM work are articulated in the executed contract between the state and vendor/contractor. All contracts go through the state procurement

process and are reviewed and approved by CMMI.

b. Recruitment of staff in support of SIM activities

SIM office

The SIM office follows state agency protocols to recruit and hire new staff. The SIM office also contacts local education institutions to recruit master's degree candidates interested in internships with the SIM office (e.g. achieving practicum credits). For state staff who contribute to SIM work as a percentage allocation of their overall work duties (100% or less), specific roles and responsibilities related to SIM are determined by the SIM office and the state agency of employment. They include:

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

External Contractors

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

A list of current Vender Contacts is attached as ***Appendix D5.***

c. Staff Training and Support

SIM office

All new staff members undergo human resources orientation at HCPF and receive mandatory training on the Colorado Open Records Act, Americans with Disabilities Act, Health Insurance Portability and Accountability Act, and cybersecurity, among others. Staff are also encouraged to take advantage of the free HCPF trainings that help them improve technological, presentation, project management and facilitation skills using new software tools. Program managers also select and attend economical subject matter trainings (approved by the SIM director) to stay current in their fields of expertise.

SIM staff receive "on the job" training by attending workgroup, advisory board and steering committee meetings, reading background materials, and shadowing other staff members. The SIM office has developed a set of office policies and procedures, which are stored online and 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 that are pursuing similar initiatives to gain background knowledge and additional subject-matter expertise.

The SIM office offers a constant learning environment in which staff regularly share key academic articles, news stories, and research findings with the team. The office also holds monthly staff meetings, biweekly meetings for project updates and weekly manager meetings to share information and update the team on the status of their work projects. Staff is also directed to the technical assistance resources available through CMMI.

External contractors

External contractors are expected to abide by all contract terms, which describe requirements and 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. In AY4, the administration and contracts program assistant will continue to document contracting processes and develop resources for external contractors.

Monitoring of continuous quality improvements efforts
The SIM office regularly submits metrics to the governor's office, which in turn is used to help populate the governor's dashboard, which is monitored by the state's Performance Management & Operations Division. The SIM office submits metrics on a quarterly basis to HCPF's department performance plan (DPP). A detailed description of SIM's methods for monitoring quality improvement efforts can be found in the program monitoring and evaluation section.

5. Leveraging regulatory authority
SIM remains committed to developing a framework that supports the integration of comprehensive physical and behavioral health services, strengthens population health, and promotes the expansion of value-based payment structures. The team believes that this will help reach SIM's goals and advance the Quadruple Aim. The SIM office will continue to engage with multiple regulatory authorities in AY4 to advance initiatives in the domains outlined below.

a. Reinforcing accountable care and delivery system transformation
The SIM team strives to bend the cost curve by providing Coloradans with access to integrated physical and behavioral health that addresses the health needs of all residents, particularly those with chronic, co-morbid physical and behavioral health issues.

Colorado law specifies the type of health care entities that must be licensed prior to providing services in the state and requirements for licensure or certification.[40] Colorado uses DORA to house nearly all licensing regulations for health care providers to minimize regulatory burden, keep licensing costs low, and facilitate collaboration among autonomous licensing boards.

The Health Facilities and Emergency Medical Services Division (HFEMS) of CDPHE issues licenses for the operation of state health care entities, inspects entities that serve Medicare/Medicaid clients in Colorado and makes recommendations to CMS regarding certification.41 The goal is to ensure that health care entities meet minimum standards of service and quality in compliance with state law and regulations, and measure a provider's ability to deliver care that is safe and adequate in accordance with state and federal law and regulations.

State statute includes a performance incentive for facilities that cooperate with investigations and have minimal or no deficient practices.[42] Colorado's licensing and certification processes do not contain any requirements or incentives aimed at reducing state health care costs or promoting coordinated planning around new services and facility construction. The team investigated the use of facility licensing requirements as a mechanism to control health care costs and decided not to take this approach, after conferring with stakeholders, which was acknowledged as outside the SIM framework scope.

In AY4, SIM will move forward with plans to link clinical care to public health and community resources with its local public health agencies and regional health connectors to address "upstream" issues. Learn more about these efforts in the plan for improving population health section.

The SIM team was a founding member and in AY4 it will continue to participate in the Colorado Quality Payment Program Coalition, a group of state and federal organizations that are committed to helping providers succeed with new payment models and gain the skills they need to collect, report and analyze data: http://www.cms.org/communications/colorado-qpp-coalition.

b. Improving effectiveness, efficiency, and mix of the health care workforce
Building a health care workforce with the capacity, training, efficiency, and effectiveness to support the Colorado

Framework integrated care model is an important component of sustaining the work that has been started with SIM funding. While the overall size of the workforce is appropriate by some measures, rural and frontier regions face shortages of primary and behavioral health care providers. In addition, Colorado has a deficit of providers in specific behavioral health specialty areas including psychiatry and professionals with pediatric expertise.

Offering integrated care in primary care settings, a foundational element of SIM, requires a different set of skills, knowledge, and attitudes than those required in traditional models. Read more about this in the practice transformation article series: http://bit.ly/2kqPCRA. Most primary and behavioral health providers are not trained to provide integrated, team-based care. Primary care and behavioral health providers need training and ongoing support to successfully work in integrated, team-based care settings. Helping them succeed requires education, training and residency approaches. This is work that the SIM workforce workgroup will continue to address in AY4 and progress made is outlined in the workforce capacity section of the report.

Colorado boasts a long legacy of thoughtful and low-burden regulation to achieve public health priorities. SIM continues to work with DORA to build a team-based health care workforce that is responsive to patient needs. Other agencies that SIM partners with to ensure that Colorado's legislative and regulatory infrastructure supports sustainable, long-term integrated care models include: the Division of Professions and Occupations at the Colorado DORA, which regulates more than 50 professions, occupations, and businesses in the state; the Health Equity and Access Branch of CDPHE, which addresses health care workforce, planning, and prevention needs in underserved communities; the Colorado Association of Local Public Health Officials (CALPHO), the statewide organization representing LPHAs in Colorado; the Colorado Behavioral Health care 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; HCPF; and professional guilds and provider associations.

Several barriers have been identified in regulatory structures that inhibit collaboration among providers, particularly at 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 patient services. In some circumstances, professional regulation differs by the type of practice facility, which causes unnecessary confusion. Current law does not clearly provide the authority to create new facility types that might be necessary for or help facilitate integrated care. Separate authorities for licensing, payment, and compliance of the physical structure often promote "siloed" decision-making by facility type. In AY4, SIM will continue to review statutory and regulatory structures and work with the aforementioned organizations to address barriers, workplace administrative inefficiencies and promote development of an oversight structure that helps deliver team-based care in which practice members – including primary care providers, behavioral health providers, care coordinators, community health workers and other non-licensed professionals and non-medical staff – work collaboratively at the top of their licensures and/or scopes of practice, to meet the needs of their practice populations.

SIM has also explored mechanisms for strengthening Colorado's workforce pipeline by developing and expanding provider education and training and connecting with academic collaborations and programs that support the education of physical and behavioral health care providers in integrated environments (see workforce capacity section for more information). To address provider shortage issues, SIM will continue to explore legislative options, such as loan payment programs that incent providers to pursue certain occupations or practice in high needs areas in AY4. One bill under consideration by the legislature is SB18-024, which allows behavioral health care professionals to participate in the Colorado Health Services Corps loan repayment system if they provide behavioral health services in a designated "shortage" area for a specified period of time. Another bill related to

workforce development in Colorado was passed in the 2018 legislative session. HB18-1086 allows community colleges around the state to offer Bachelor of Science-level nursing degrees, given board approval. During the 2018 legislative session a bill was also passed to allow Colorado to join an enhanced Nurse Licensure Compact that allows nurses licensed in a participating state to work in other participating states as well.

Finally, in alignment with Colorado Public Health Act of 2008 (C.R.S. 25-1-501 et seq.), SIM will continue to fund regional health connectors (learn more in the plan for improving population health section) to connect providers with community resources.

c. Aligning state regulations and requirements for health insurers

The Colorado Division of Insurance (DOI) within DORA, is the primary regulator of health insurance carriers in the state, which is structured around key functions including company licensing, producer licensing, product regulation, market conduct, financial regulation, and consumer services. The DOI's regulatory role varies across insurance market segments and includes four major responsibilities: rate regulation; consumer protection; financial solvency; and market regulation. There is a unique collaboration between health plans in Colorado that will help the SIM team make progress toward its goals in AY4. Colorado health plans have had an established framework to align efforts since the "Alignment Bill" (HB 13-1266) was passed in 2013 and, as previously noted, six payers participate in a Multi-Payer Collaborative (MPC) that supports SIM. The SIM team works closely with MPC payers to help communicate the benefits of supporting integrated care through data collection and analysis to show how integrated care improves patient outcomes and lowers costs.

Colorado SIM will build on public and private payers' commitments, demonstrated though individual initiatives and joint participation in CPCI and CPC+ to help providers succeed with alternative payment models and ultimately move toward value-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.

d. Assurance of payment reform alignment

The SIM office continues to align clinical quality measures and practice transformation activities that help improve partnerships between health plans and providers. The SIM team invested in a common data aggregation tool that helps SIM providers access claims utilization data to assure quality and alignment of measures. This type of work helps build a sustainability framework for integrated care because it will help providers use data in effective ways to identify costs of care and tweak processes to improve outcomes and lower costs. The team has successfully secured access to this tool for cohort-2 practices, and extended access for cohort 1 practices.

As Colorado payers continue to embrace and expand value-based reimbursement models, the ability for practices to access and use data effectively will become increasingly important. In AY4 the SIM team will continue to work with Best Doctors, the vendor for the data aggregation tool, and practices to highlight the unique value of this tool and the ways in which it will help practices succeed with myriad payment reform initiatives.

In AY4, the SIM team will continue to work closely with HCPF on its Accountable Care Collaborative (ACC) Phase 2 model. To increase access to behavioral health services, Medicaid will now cover six low-acuity behavioral health visits on a fee for service basis, which will be reimbursed without the need for a qualifying diagnosis. Treatment for higher acuity qualifying diagnoses will continue to be covered under the capitated model. It will move financing for physical and behavioral health benefits under a single framework—the Regional Accountable Entities (RAEs), which addresses a key issue of payment fragmentation in the system. Members of the SIM team will continue to be involved in these discussions in AY4. The reimbursement structure will allow for some potential utilization and

outcome-oriented elements, including quality metrics, incentive payments, and shared savings arrangements. Another important element of ACC Phase II is to increase collaborative care beyond the walls of the Primary Care Medical Provider's office through the creation of health neighborhoods, which include specialists, hospitals, oral health providers, and other ancillary providers. HCPF has started moving toward value-based payments.

e. Integrating value-based principles in health insurance plans

Commercial payer commitments to alternative payment models (APMs) are voluntary. The goal is to help providers succeed in these APMs with coaching that helps them with practice transformation as well as data collection, reporting and analysis so they can progress toward shared savings/shared risk models, and ultimately to prospective, outcome-based payments based on patient populations.

Colorado statutes and regulations neither prohibit or encourage APMs or the use of value-based insurance designs. In AY4, the SIM team will work with DOI to identify ways the state can advance primary care, value-based payment opportunities for providers.

f. Integrating transformation-based teachings into medical education programs

Colorado has a robust academic training environment of universities, colleges, and educational institutions with two medical schools, a school of public health, two physician assistant programs, seven doctoral psychology programs, three schools offering Master of Social Work degrees, and numerous programs in nursing that add to the capacity of whole-person health care teams 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. The University of Colorado Department of Family Medicine (UCDFM) is a primary partner in advocating for this work, and SIM will continue to be a resource for these programs in award year 4. More information about this can be found in the Health Resources and Services Administration section of the ops plan.

6. Stakeholder engagement

a. Convening SIM stakeholder workgroups

The principal avenue for the SIM team to engage stakeholders will continue to be through these seven, topic-specific workgroups in AY4:

- Consumer engagement;
- Evaluation;
- Health information technology (HIT);
- Policy;
- Population health;
- Practice transformation; and
- Workforce development.

Charters and objectives:
www.colorado.gov/healthinnovation/workgroups.

During AY4, The SIM team will continue to capitalize on the work done to reassess workgroup structure (Appendix E1) in AY3 that helped ensure effective use of time and resources. The team moved some meetings to bimonthly and reassigned some volunteers to different workgroups to cross-pollinate ideas and subject matter expertise, and to ensure greater buy-in for foundational changes proposed by SIM stakeholders.
Four workgroups meet at least once per month while three meet every other month. In AY4, the SIM office will

continue to disseminate information to stakeholders, solicit feedback on project implementation when appropriate, and encourage stakeholders to make recommendations to the SIM office. Since Feb. 2015, the workgroups (combined) have met more than 200 times and continue to refine their goals and objectives to align with SIM program implementation as it evolves.

In preparation for the 2018 All-stakeholder Convening held in Denver, Colorado, all workgroups re-evaluated their workgroup charters to ensure that workgroup goals reflect current work and align with overarching SIM goals. Updated charters can be found on the SIM website (www.colorado.gov/healthinnovation/workgroups). These documents were a focal point of the All-Stakeholder Convening and act as guiding principles for the workgroups as project implementation advances. In AY4, workgroups will continue to look to these documents as focal points for ensuring collective impact of all seven stakeholder groups.

Workgroups consist of approximately 18 members for a total of 129 participants. Members were initially selected in an open and competitive application process based on their subject-matter expertise and ability to represent key stakeholder groups across the state. SIM program managers continue to retain active members to participate in workgroups and the application remains open to ensure continued access to participating in SIM although membership is limited to underscore the importance of participation. Members are required to attend 75% of all workgroup meetings and operationalize SIM in a thoughtful way.

To maintain diverse key stakeholder perspectives, workgroups have looked at their membership rosters and identified areas of expertise that might be lacking. There has been some turnover, due to job transition, inability to attend meetings and changing priorities, and workgroups have taken the opportunity to ensure that the right people are at the table. In collaboration with the SIM office, new members have been identified and added to workgroups. Co-chairs are cognizant of the importance of diversity in the room (geographic, background, expertise, etc.) For additional details about workgroup structure and interface with the SIM governance model, see the SIM governance section.

In early 2018, the SIM office worked closely with the program office for the Regional Health Connector (RHC) program to invite and select one RHC representative to join each SIM workgroup. There was a competitive application process and participants were chosen based on topic expertise and ability to add diverse perspectives to the conversation. This effort is also meant to further strengthen the relationship between RHCs in the field and the SIM program. RHCs seated on different workgroups are highlighted in blue in Appendix E2.

b. SIM payment reform workgroup update

As referenced in the SIM governance, the SIM office repurposed the payment reform workgroup as the Multi-Stakeholder Symposium (detailed later in this section). Members of the payment reform workgroup were asked to participate on one of the other workgroups that aligned with their expertise. The goal is to ensure that payment reform discussions are woven throughout the fabric of all SIM discussions to ensure ongoing success of integration efforts. SIM office staff made personal phone calls to each workgroup member to explain the change and determine which workgroup could best use the volunteer's expertise. For example, one member of the workgroup, who represents a private foundation, now sits on the Practice Transformation workgroup, which previously did not have any representation from the philanthropic community. And the chair and co-chair of the payment reform workgroup participate in SIM steering committee meetings to ensure that all workgroups can engage with payment-reform related issues and participate in Multi- Stakeholder Symposium meetings. This has been a successful shift and the SIM team will continue to capitalize on these discussions with stakeholders in AY4.

c. Demonstration of diversity

The following table demonstrates the distribution of organizations with at least one representative on a SIM stakeholder workgroup. The groups have a health care focus and represent broader topics and interests that support the overall objectives of SIM. The SIM office makes every effort to preserve diversity of workgroup membership as new members are added:

Commercial payers/purchasers

Anthem Blue Cross Blue Shield

Kaiser Permanente

Rocky Mountain Health Plans

UnitedHealth Group

Community-based and long-term support providers

Arapahoe Douglas Mental Health Network

Centennial Area Health Education Center

Community Health Partnership

Colorado Community Managed Care Network

Colorado Community Health Network

Grand County Rural Health Network

Greater Metro Denver Health care Partnership

Mile High Health Alliance

National Council for Behavioral Health

North Colorado Health Alliance

Northwest Colorado Community Health Partnership

The Chronic Care Collaborative

West Mountain Regional Health Alliance

Consumer advocacy organizations

Alliance Colorado

Citizens for Patient Safety

Colorado Center on Law and Policy

Colorado Health Institute

Colorado Consumer Health Initiative

Health systems and providers

Centennial Mental Health Center, Inc.

Centura Health

Children's Hospital Colorado

Deb Parsons, MD, LLC

Denver Health

Jefferson Center for Mental Health Kaiser

Permanente

Mental Health Center of Denver Salud Family

Health Centers Swedish Family Medicine

The Denver Hospice

University of Colorado Health (UCH)

Higher education

Metropolitan State University of Denver, Department of Social Work

Colorado School of Public Health

Colorado State University, Department of Social Work

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

El Paso County Public Health

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

Office of Behavioral Health

Other

Caring for Colorado Foundation

Center for Improving Value in Health care

Colorado Academy of Family Physicians

Colorado Association of Addiction Professionals

Colorado Behavioral Health care Council

Colorado Children's Health care Access Program

Colorado Medical Society

Colorado Nurses Association

Colorado Regional Health Information Organization (CORHIO)

Early Milestones Colorado – LAUNCH Together

empowered Decisions

The Lewin Group

Milliman

Physician Health Partners

Quality Health Network

Rose Community Foundation

ValueOptions

Wellbeing Trust

(For a complete list of SIM workgroup members, see ***Appendix E2***.

Strategy for future engagement

The SIM office will continue to convene workgroups at least once a quarter and more often when needed until the end of the initiative. In the first year, the SIM office convened most workgroups at least once per month. In the first, second and third implementation year, workgroup convening has changed as outlined above, and will continue in AY4 to capitalize on staff and volunteers' time. In AY4, the team will look forward to adding consumers to SIM workgroups as a result of the consumer engagement outreach work that is being done with Arrow Performance Group.

d. Tracking progress and key dependencies across workgroups

The SIM stakeholder engagement program assistant tracks progress and key dependencies across workgroups. This position, which was recently vacated, provides day-to-day support for all workgroups and stakeholder engagement events, the steering committee, and advisory board. With a unique vantage point to monitor work across the diverse workgroups, this staff member identifies areas of potential collaboration and dependency. The program assistant documents and monitors work and activities across all groups to identify areas of overlap and potential synergy.

In addition, each SIM office staff member who supports a workgroup completes a monthly status summary that outlines progress. The report includes information on areas of collaboration with other workgroups and identifies possible risks and mitigation strategies. The program assistant compiles monthly reports and assists in identifying key dependencies across workgroups. These summaries are shared with all workgroup members via email and the designated file-sharing platform (Basecamp) to increase transparency about work done in each workgroup. In AY4, SIM team members will continue to provide high-level overviews of other workgroup meetings held during the previous month. These in-person updates help ensure cross-pollination and alignment of activities and are a welcome response to feedback from workgroup members, who told the SIM team they didn't know what was going on across the initiative.

e. SIM All-stakeholder Convening

An All-stakeholder Convening was held in February 2018 in Denver to ensure cross-pollination of ideas and share collective progress on work to help health care providers integrate behavioral and physical health and to succeed with value-based payment models. The meeting was designed by SIM workgroup co-chairs during Steering Committee meetings to ensure active dialogue and information sharing and was open to all SIM workgroup members, the advisory board and several vendor partners.

More than 100 key SIM stakeholders attended the convening, which featured a patient story recounted by Mary Catherine-Conger, working sessions that allowed workgroup members to sit with other workgroup members, and workgroup-specific discussions around sustainability and their ongoing commitment to SIM. The six-hour meeting also featured a keynote address from Colorado Lieutenant Governor Donna Lynne, who re-energized SIM stakeholders with the sentiment that "We can now say to CMS [Centers for Medicare & Medicaid Services] and to later adopters, 'Your patients are going to have better outcomes because of this work.'"

The day was largely centered around eight beacon priorities (see ***Appendix E3***) for continued work in the last months of SIM, along with thoughts on sustainability that were developed by the SIM Steering Committee.

f. SIM multi-stakeholder symposium

While payment reform workgroup members were added to other groups to voice a payer perspective across SIM when the payment reform workgroup disbanded, the SIM team recognized the need to open dialogue between SIM providers, practice transformation organizations, and health plan representatives. The inaugural meeting was hosted in January 2017, and SIM will continue to host these stakeholder meetings regularly. Meetings are dedicated to focused discussions among attendees, who are encouraged to participate in an open dialogue among representatives from health plans, practices and practice transformation organizations (PTOs) to foster stronger

partnerships. Participants reflect on progress made to date with practice transformation activities and receive updates on SIM. In AY4, there will be a concerted effort made to coordinate SIM and CPC+ initiative meetings. In January 2018, the first symposium was held for both SIM cohorts 1 and 2, which provided a good opportunity for new practices to hear from cohort 1 about the benefits of SIM participation and the strengthened relationship between practices and payers, which is important for success in value-based payment arrangements after SIM concludes. The SIM team plans to build on these conversations during the April 26th symposium and in AY4.

h. Leveraging other stakeholder groups

The SIM office recognizes that a wide array of stakeholders has been convened to help accelerate statewide health transformation. Rather than relying entirely on SIM workgroups and events, the SIM office also collaborates with and leverages 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:

- Access to Specialty Care Work Group) for Pediatric patients
- Colorado Health Care Evaluation Collaborative (convened by HCPF)
- Colorado Health Extension System (convened by University of Colorado Department of Family Medicine);
- Colorado Quality Payment Program Coalition;
- Colorado School Based Health Affinity Group;
- Communication meetings for all state departments; and
- Community medical home forum (Convened by CDPHE);
- Community Norms Workgroup (Convened by CDPHE);
- Department of Health Care Policy & Financing weekly meetings about the APM;
- eHealth Commission meetings (convened by the Office of eHealth Innovation);
- Health cabinet meetings (convened by the governor's office);
- MPC meetings (in conjunction with CPC+);
- School Based Health Services Affinity All-states Group;
- SIM Pediatric Stakeholder Group (convened by CDPHE)
- State-designated entity (SDE) action committee (state HIT steering committee);
- Workforce cabinet meetings (convened by the governor's Office);
- Workforce & Education Workgroup (convened by the Colorado Department of Labor and Employment).

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

This group, convened by CDPHE and SIM, meets quarterly to engage Colorado agencies, families, medical facilities, organizations and policymakers as they implement the patient-centered medical home (PCMH) model. To promote alignment between Colorado PCMH initiatives and SIM integration efforts, the SIM office has committed to presenting at all community forum meetings during the initiative.
Since the inaugural meeting, SIM office and CDPHE staff will continue to meet and partner with CDPHE to run these forums in AY4. Here is an example of topics suggested for the 2017/2018 forums:

- Update on Accountable Care Collaborative (ACC) 2.0 - Susan Mathieu, ACC Manager; Department of Health Care Policy and Financing (HCPF)

- Presentation: CO Health Access Survey (CHAS)- Jeff Bontrager, Director of Research on Coverage and Access; Colorado Health Institute (CHI)
- SIM and HCPF partnership to enhance telemedicine and eConsult efforts across Colorado - Barbara Martin, SIM Director, Governor's Office; and David Ducharme, Program Innovation Section Manager, HCPF
- Panel Discussion: Effective Strategies for Improving Access to Pediatric Specialty Care from the payer, provider, state and community perspective; Plus Updates from Health Alliances and Foundations involved in eConsult efforts
- Update on SIM: Community Engagement Efforts - Shi Lynn Coleman, Workforce & Population Health Program Manager
- Opportunities to Improve Access to Developmental Evaluations (DE) Panel Presentation and Discussion - Dr. David Keller, Pediatrician and Vice Chair of Clinical Affairs and Clinic Transformation, University of Colorado School of Medicine; and Dr. Sandy Friedman, Section Head, Developmental Pediatrician; Director, JFK Partners; UC School of Medicine

Engaging consumers

In AY4 the SIM office will continue to work with a dedicated team of volunteers on the consumer engagement workgroup, who possess expertise in the field of consumer advocacy. A new co-chair, Caitlin Westerson, joined the workgroup effective March 2018. Caitlin is the policy manager at the Colorado Consumer Health Initiative (CCHI) and brings a wealth of knowledge, leadership, and experience to the consumer engagement workgroup.

The SIM team has recognized a need to incorporate a wider perspective from the consumer population, particularly those who are insured by Health First Colorado. In the summer of 2017, Arrow Performance Group (APG), was contracted with to build a base of community leaders who will bring a health equity lens to ongoing conversations about transforming health care delivery systems.

APG, with support from the SIM office through July 2018, will conduct consumer outreach activities, including collecting qualitative and quantitative data from health care consumers regarding the health care system. This community engagement work is taking place in two medically underserved regions chosen by APG; regions include parts of Adams, Arapahoe and Denver for an urban perspective and Pueblo, Crowley, Otero and Prowers counties for a rural perspective. APG and identified community liaisons have worked with active local public health agency (LPHA) grantees and regional health connectors (RHCs) to enable close collaboration to engage consumers as active health care leaders in their communities. Community liaisons from these target communities will use a community strengths-based perspective to help patients and community members identify barriers to health, educate them on health systems transformation efforts in their communities, and help develop their leadership so they engage in SIM's workgroup structure to influence SIM activities. We will target community members who are participating in value-based payment reform programs and accessing integrated behavioral and physical health care; although, all health care consumers in these regions are eligible to participate.

The consumer engagement workgroup has been actively involved in this scope of work from the beginning and will continue to give input on the direction of this work in AY4.

The advisory board (AB) has been involved with and kept apprised of the SIM community engagement strategy managed by APG. There are two AB members, who represent consumer interests and have provided input into the project by working with the SIM program manager. The RHCs in both chosen areas for the work have been greatly involved since the beginning of the project. They have helped organize introductions and key stakeholder meetings with community leaders. They have helped identify potential community leaders and helped distribute the survey.

Engaging tribes and the American Indian population

To date, CDHCPF, CDHS, and CDPHE have signed agreements with the two tribes to 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 goal of reaching consensus on issues."[3] The consultations will help develop a relationship based on trust an effort to understand and consider any effects an undertaking may have on the consulting parties. SIM team members have consulted with TA partners about how other SIM states have worked with tribes to extend the initiative to these communities and will continue to seek guidance in AY4.

The SIM team is collaborating with HCPF to see how the team can work with four new positions created to coordinate health care issues between tribal members and the state. In AY4, the SIM team will meet with these new team members to identify ways we can work with the tribal members. Background on the positions: Two positions will be at HCPF to coordinate services between IHS/Tribal and Medicaid providers, one position would be in the Lieutenant Governor's Office in the Colorado Commission of Indian Affairs to lead this cross functional health team and the final position will be at the Department of Human Services, Office of Behavioral Health to provide training and technical assistance to behavioral health providers delivering culturally responsive treatment to American Indian and Alaskan Native people, who seek care throughout the state.

Strategy for future engagement

While the SIM office will maintain its relationship with Denver Indian Health and Family Services, it seeks to expand its engagement beyond the Denver metro area. Further efforts will focus on engaging the Southern Ute and Ute Mountain Ute tribes. The team has presented to the Colorado Coalition of Indian Affairs and had conversations with state leaders about how to approach work with the tribes to share lessons learned and engage these communities in meaningful ways. Initial conversations have been well received.

i. Engaging the public

SIM website

The SIM office continues to update and maintain its website: www.colorado.gov/healthinnovation, which serves as a central platform for public-facing information, including:

- Articles about SIM, its mission and the work the initiative funds;
- Videos and podcasts about the work practices are doing to integrate care and test alternative payment models;
- The SIM blog;
- Advisory board and workgroup charters;
- Open funding opportunities (RFAs, RFPs, RFIs, etc.);
- SIM resources (FAQs, one-page overviews, informational presentations, etc.);
- SIM newsletters and other health care transformation news;
- Data published by the SIM office; and
- Public meeting information (detailed below).

Public meetings

All workgroup, steering committee, and advisory board meetings are open to the public. The SIM office maintains the following process for communicating information about meetings:

- **Notification:** All public meetings are posted on the calendar section of the SIM website at least two

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

weeks in advance of the meeting. Interested parties can receive updates to the SIM calendar by subscribing to Rich Site Summary (RSS) feed or syncing calendars with the SIM calendar via iCal. In addition, anyone is welcome to sign up for event invites through the public interest form located on the SIM website.

- **Statewide participation:** All public meetings have a phone and webinar option so workgroup members and members of the public, who live outside the Denver metro area, can participate.
- **Public comment period:** All public meetings include a time 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.

SIM videos

A series of videos highlight the unique value of SIM, its mission, goals and a few of its success stories told from the perspective of payers, providers, practice transformation organizations (PTOS) and community mental health centers. The short videos feature many of the faces and voices of people who have been integral in creating, supporting and furthering SIM's mission to integrate behavioral and physical health. They talk about why it matters to health care providers, patients and insurance companies that are working with SIM to create sustainable pathways to integration. Links:

- What is the Colorado State Innovation Model (SIM)?
  - https://www.youtube.com/watch?v=6yCxJpMomOg&feature=youtu.be
- Practice transformation and the Colorado State Innovation Model (SIM).
  - https://www.youtube.com/watch?v=JNInICY9oMw&feature=youtu.be
- Payers on board - Colorado State Innovation Model
  - https://www.youtube.com/watch?v=_2ZcOr3Gg9I&feature=youtu.be
- SIM provider talks about his practice's involvement in the initiative
  - https://www.youtube.com/watch?v=ol6NbNLp0tQ&feature=youtu.be

SIM social media, newsletters, podcasts and blog

SIM has bolstered social media efforts during the past several months. The team maintains an active Twitter account (@SIM_Colorado), a LinkedIn account (https://www.linkedin.com/company-beta/15244374/?pathWildcard=15244374), a Facebook page (https://www.facebook.com/colorado.sim.7) to engage diverse audiences and a blog (https://www.colorado.gov/healthinnovation/SIM-blog) that was launched in 2018.

The SIM office emails a monthly stakeholder newsletter via Constant Contact to a list of more than 1,800 subscribers. It is intended for a wide range of SIM stakeholders and communicates key updates, such as the release of RFPs and upcoming deadlines. In addition, a provider newsletter is published every other month and focuses on pertinent information for SIM practices. Archived copies of these newsletters are available: https://www.colorado.gov/healthinnovation/news-7.

The SIM office podcast series "Innovation Insights" features different SIM team members and partners in an information discussion about the initiative and its work. Several podcasts, all of which are available to view on the Sound Cloud platform, have had more than 100 views: https://soundcloud.com/user-118904494. A few examples:

- SIM data: The story behind the numbers
  - Learn about the types of data SIM is collecting and how it is being used to evaluate the progress of the initiative.
  - Guests: SIM data experts

- Colorado State Innovation Model Patient perspectives: SIM practice team hears patient talk about how their work improved her life
    - Transforming practice operations to be more patient-centered are acknowledged by a patient in this episode of Innovation Insights, in which care team members from Roaring Fork Family Practice, a SIM cohort-1 practice in Carbondale, Colo., hear a patient's perspective.

Logging public comment

The public can submit questions or comments through the SIM website and during public meetings. In addition, the SIM office created a public comment log to track these comments, allow staff members to identify trends or themes to address and ensure that timely responses are received.

Annual SIM outreach tour

The SIM office will try to coordinate this tour with the consumer engagement work in AY4 to engage stakeholders outside of the Denver metro area in their local communities.

Future SIM outreach tour approach

We are evolving the original SIM outreach concept to involve regional health connectors (RHCs), local public health agencies (LPHAs) and SIM cohort-1 practices that will tell their stories about how SIM has worked in their practices. We also hope to coordinate the tour with the work that Arrow Performance Group is doing to engage consumers to capitalize on staff time. The intent is to dovetail with existing meetings scheduled by partners or medical societies and coordinate scheduling with RHC and LPHA partners. This approach is also meant to foster a sense of collaboration and coordination among SIM partners to showcase the wide-reaching aspects of SIM.

The SIM office will continue to reach out to medical societies to identify dates for upcoming meetings in AY4, and partners at CDPHE are helping connect team members with the LPHA administrative lead to identify upcoming events across the state for possible presentation opportunities. Due to limited staff time and turnover, this effort has been limited in scope to date, but the goal is to continue the efforts to partner with state agencies and SIM-funded partners to continue to increase awareness of SIM.

The SIM office is also exploring the idea of having SIM booths/exhibits at appropriate conferences in AY4 and will continue to collaborate with LPHAs and RHCs, who can talk about their work to highlight unique aspects of SIM that are being implemented in the community.

SIM conference

The initial SIM narrative indicated that a conference would be convened every six months but conversations with stakeholders revealed that an annual conference would be better received by volunteers, some of whom meet monthly for SIM workgroups, and would be more feasible, due to limited staff time. As a result, the team hosted its first All Stakeholder Convening (ASC) in February 2018, which was well received. The team plans to host another ASC in AY4 to celebrate some of the initiative’s successes and continue the sustainability discussion.

Incorporating the consumer perspective

The SIM office is committed to incorporating consumer needs, wants, and preferences in all aspects of its work. 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 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 people who represented consumer interests. The governor's office of Boards and Commissions ran a competitive application process and selected the following 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 E4.***)

These two consumer representatives continue to ensure that consumer perspectives are considered in all major decisions moving forward.

The SIM team has invested more energy in social media posts that have attracted attention from patient advocacy groups and a growing number of "followers," who are spreading the message about the value of integrated health to patients across the state.

The team will continue to participate in the HCPF patient advisory council in AY4, which helped the team create patient-facing materials for SIM practices to distribute in publication channels, in their waiting rooms and on their websites. The team will continue to produce these types of materials to help SIM practices highlight the work they're doing with patients and initiate conversations about integrated care.

Staff continues to seek patient stories to share online and published two podcasts with patients in 2017. The team will continue to optimize relationships in AY4 and believe the work that Arrow Performance Group is doing to engage consumers will help the team address the consumer engagement piece of the SIM puzzle in the future, and hopefully add more consumers to the workgroups.

The goal is to have a consumer representative join on each of the seven SIM workgroups to ensure that a consumer perspective is infused throughout all workgroup activities, and leveraged for collective impact.

j. Requirements of participating payers

Please see the payment and service delivery models section.

k. Requirements of participating providers

Please see the SIM payment and service delivery models section.

l. Agreement between payers and providers

Please see the payment and service delivery models section.

7. Health Care Delivery System Transformation Plan

a. Payment model(s) and service delivery models(s)

Payment model(s)

Payment reform is a key component of SIM's efforts to improve access to integrated physical and behavioral health care in coordinated community systems, with value-based payment structures, for 80% of Coloradans by 2019. Current payment systems, which reimburse care primarily through fee-for-service (FFS) payments and use a

range of payer-specific measures to evaluate outcomes, compound the fragmented nature of care delivery in the state. To achieve lasting and sustainable change, payment reform must support efforts to transform health care delivery in meaningful ways that resonate with health care providers as well as health plans. The SIM team will explore a different approach to payment reform in AY4 with the help of CMMI team members and a collaboration of state departments and health care industry partners. This work represents a key component to sustaining the work that has been initiated by SIM and the Comprehensive Primary Care Plus initiative across the state.

Overview of payment reform in Colorado

In Colorado, there is significant variation among payers, which range from small, local non-profit organizations to large, publicly-traded health insurance companies and sophisticated systems. These organizational and structural differences among payer organizations make the spread of value-based payments across payers with varying resources, capacities and strategies, an ambitious enterprise. Despite these challenges, multiple public and private value-based payment initiatives are underway in the state. During the planning period for SIM, payers indicated a high degree of interest in pursuing value-based payment 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 new processes and support for data sharing. The SIM initiative will continue to play a leading role in addressing these issues and other barriers to the adoption of value-based payments through its work with the Multi-Payer Collaborative (MPC).

In AY4, work to explore an all-payer model in Colorado will continue with the governor's office, SIM, state agencies, the Colorado Hospital Association and other stakeholders. The SIM team has convened biweekly meetings with a core all-payer team that includes state leaders and representatives from the Colorado Hospital Association to ensure collaboration and sustainability. The team is considering how to create a Colorado-specific, value-based payment model that increases affordability and encourages stakeholders to deliver patient-centered, team-based care to improve health outcomes and reduce or avoid costs. The team is considering a variety of mechanisms to achieve this goal, including global budgeting for some hospitals as well as an advanced alternative payment model (APM) for primary care with a specialty provider opportunity. Colorado has a history of investing in innovative care models and market-driven reforms that create and support a comprehensive, patient-centered health care system. This all payer work must build on that strong foundation of care in the state, and must be in alignment with existing initiatives including HCPF's Hospital Transformation Program and the transition to Regional Accountable Entities as part of ACC II. We plan to meet with CMMI leadership in the coming weeks to discuss an outline of the proposal and whether an all payer model makes sense for Colorado.

A key piece of the SIM office's strategy for AY4 is exploring opportunities for primary care providers to participate in advanced APMs. The team hired a consultant to help us identify possible policy levers as well as federal and state regulations and initiatives that might help efforts to offer an advanced APM to more providers in Colorado. The consultant will deliver her policy recommendations during AY4, which will inform the final sustainability plan.

All Payer Model Exploration - Global Budget and Advanced APM Opportunities

Colorado has a history of pursuing innovative healthcare demonstrations in the state, including the State Innovation Model (SIM), the Comprehensive Primary Care Initiative (CPCi) and Comprehensive Primary Care Plus (CPC+), the Transforming Clinical Practices Initiative (TCPi) and the Accountable Health Communities Model (AHC). Colorado has taken a multi-tiered approach to health care reform that aligns clinical quality measures to reduce provider burden, builds skill sets and ensures sustainability. We hope to sustain and expand the progress made to date and help providers, hospitals and payers work together to succeed in the new health care environment. In AY4, the SIM team will continue conversations with various stakeholders, including state agency leaders, to explore an all payer model in Colorado and the tools necessary to transform care delivery and payment in the state.

An all-payer opportunity would help sustain health care transformation initiatives in the state (outlined above) that are helping primary care and specialty providers succeed with alternative payment models (APMs). The logical next step is to extend these efforts to include hospitals and pursue a statewide APM that connects these dots and ensures that all providers in the state see a sustainability path to continue the healthcare reform work they have started.

We believe one key tool to achieving this shift in care delivery and financing within the all payer context is hospital global budgeting. SIM meets weekly with the governor's office, HCPF and the Colorado Hospital Association (CHA) to explore how global budgets could work in certain regions. Specifically, we are exploring opportunities to foster collaboration between CMS, hospitals, payers, providers and consumers to help rural hospitals and communities provide the right care for their populations. A global budget tool could help provide hospitals in rural areas and their local communities with the budgetary certainty to right-size local delivery of services. Evidence-driven decisions – based on local data, free from the need to focus on volume growth and fee-for-service revenue opportunities – will give communities the information and capacity to achieve high quality at an appropriate cost. Additionally, this tool will help hospitals add services that are more critical to current local needs by providing stable funding and resources to allow for transition towards value-based care. Providing the time and capacity for rural hospitals to transform their operations and approaches to best serve their communities and integrate with other efforts underway to improve health will result in improved quality and access to the most important services. We are pleased to have been accepted into the State Policy Academy on Global Budgeting for Rural Hospitals, hosted by Johns Hopkins University in collaboration with the Milbank Memorial Fund, the Robert Wood Johnson Foundation's State Health and Value Strategies, and the National Rural Health Association on May 30, 2018, in Baltimore, MD. Key representatives from CHA, HCPF, and SIM will be attending, where we hope to further explore the tools – including global budgets – necessary to transform care. We look forward to engaging with national and state leaders, who have experience with implementing global budgets and learn how this tool might provide the stability and predictability needed in rural hospitals to right-size care delivery and ensure quality, affordable care is available to Coloradans.

The future healthcare transformation efforts in Colorado must align with the Health First Colorado (Medicaid) Accountable Care Collaborative – the core care coordination component of the state's Medicaid program – as well as the 1115 waiver for hospital transformation that Health Care Policy and Financing (HCPF) will submit, as endorsed by 2017 legislation. Colorado's Medicaid program is committed to aligning performance incentives for different provider types across the entire delivery system, and the HCPF team is working with hospitals on payment models that incent transitions of care, data sharing, and support integrated care.

It is important to have buy in from multiple stakeholders, who are involved in a potential global budget opportunity, including payer organizations. Current practice transformation work in Colorado is supported by a Multi-Payer Collaborative (MPC) that represents public and private payer organizations in the state that discuss ways to transform care, support effective data use and reform payment in Colorado. A multi-payer approach is crucial for achieving systemwide transformation goals, and Medicare's leadership and active participation in the MPC has been essential. Alignment among MPC members on payment models, quality metrics and data aggregation are essential to transforming care in meaningful ways while reducing provider burden, and we hope this unique collaboration among payers in Colorado will contribute to successful transformation efforts.

Building on a strong primary care foundation, Colorado will benefit from an all-payer model that includes Medicare participation and creates more coordinated patient care and consistency for providers. Guidance from CMS indicates that CPC+ providers will be eligible for the advanced APM under MACRA and we would like to see non-

CPC+ providers have the same opportunity. We are engaged in efforts to see how we can continue to bolster the primary care infrastructure in the state by building on SIM, CPC+ and the Medicaid APM. One exploratory path, for which we have hired a consultant to assist, includes gaining a better understanding of the tools and policy levers needed to create a voluntary statewide Advanced APM that would engage commercial and public payers. A Colorado-specific Advanced APM would create a MACRA Quality Payment Program (QPP) on-ramp for Medicare providers to take incremental steps toward participation, which would make them eligible for the 5% Medicare incentive payment. As providers meet requirements for the Advanced APM, they could qualify for inclusion. Not only will this be of great benefit to Colorado providers, it creates a broad foundation that will enable the regional hospital framework to be successful.

Our partners at HCPF, specifically on the team charged with development and execution of the Medicaid APM for primary care, were in conversations with CMS in AY3 about potentially applying to become an Advanced APM under MACRA. However, due to a variety of concerns, including one regarding threshold calculations for Medicare/ Medicaid providers, HCPF decided not to apply this year. The SIM team continues to participate in weekly Medicaid APM meetings and intends to continue working with them about exploring the potential of applying next year.

We believe it is crucial to build on the strong foundation of primary care in Colorado and expand the opportunities for providers to participate in value-based payment models. An all payer model, with global budget and alternative payment model components, would be key to sustaining the payment reform work currently underway in our state. We are still in exploratory stages and look forward to continuing the discussion with CMMI and our key stakeholders in AY4.

This work is a key piece of the SIM office's strategy for AY4 is exploring opportunities for primary care providers to participate in advanced APMs. The team hired a consultant to help us identify possible policy levers as well as federal and state regulations and initiatives that might help efforts to offer an advanced APM to more providers in Colorado. The consultant will deliver her policy recommendations during AY4, which will inform the final sustainability plan.

SIM approach to payment reform

Engagement with public and private payers

SIM has worked with payers and providers to develop a payment reform strategy that meets these industry players where they are and provide opportunities for communication between payers and providers to discuss the need for alternative payment models that incent quality and value rather than volume. SIM is committed to supporting payment reform and has aligned measures with initiatives including the Comprehensive Primary Care Plus (CPC+), Health First Colorado's Accountable Care Collaborative program (ACC), the Transforming Clinical Practice Initiative (TCPi) and the Quality Payment Program (QPP) to reduce provider reporting burden. Using this platform has helped ensure maximum payer participation in SIM and catalyze SIM's efforts to reach 80% of state residents by 2019.

The MPC represents public and private payers that share a commitment to support and expand accountable, whole-person, patient-centered care transformation through a variety of initiatives. As outlined above, seven payers signed a Memorandum of Understanding (MOU) with the SIM office (see ***Appendix D3***), that outlines a commitment to work with SIM to transform the way physical and behavioral health care is delivered and financially supported in practices selected for SIM within their networks. This group now includes six health plans as explained earlier, are collaborating to:

1. Focus on primary care practices and behavioral health settings seeking to integrate care;

2. Support providers who deliver and coordinate integrated care that improves population health, and increases quality while reducing costs;
3. Increase providers' abilities to manage whole-person care;
4. Develop necessary infrastructure to support care integration and delivery of whole-person care; and
5. Encourage practices to continually evolve towards higher-levels of integration via transformation of care delivery support through alternative payment models (APMs).

Shortly after the launch of the first cohort in the spring of 2016, it became clear that there was a disconnect between providers and payers in terms of what "payment support for SIM practices" entailed so the SIM office has spent considerable time and effort to help providers understand expectations and has encouraged more regular communication with payer representatives. This is one of the reasons the Multi-Stakeholder Symposiums (outlined above) are hosted three times annually. Colorado payers recognize the value of integrating physical and behavioral health. They also recognize the importance of and have invested in value-based payment models in the state. Payers participating in SIM were told that their existing value-based payment models would be acknowledged as support for SIM practices as outlined in the SIM proposal. For some payers, these models include behavioral health. For this reason, practices that were part of a value-based initiative or model might not have received a new contract or increase in financial reimbursement for their participation in SIM.

The SIM team created a communication template for MPC members to send to SIM practices and encourages payers to send communication on a regular basis. The team also created a payer resource on the SIM website with information about what payment support looks like.

To encourage more consistent communication between payers and practices, the SIM team created an online "Resource Hub" folder for payer organizations. This folder includes updated practice lists for each cohort including practice lists specific to each payer indicating which practices a payer supports along with letter templates that payers can customize and send to their practices. These letters are intended to explain specific payment support to the practice, including payment model details, whether the practice is in a new or existing payment model, and who to contact at the payer organization for SIM-support questions. On the practice side, we continue to emphasize the importance of practice representatives reaching out to their payer organizations to foster that payer-practice relationship and to receive payment model information.

Please see ***Appendix F1*** for a description of what each payer's payment model entails. The team also created a guide for practice transformation organizations (PTOs) that explains payer support in the SIM initiative so that PTOs can answer practices' questions on this topic. The SIM team suggests that PTOs work with all practices to create a master document outlining payer contacts the practice works with to expedite answers about a specific payment model. The team suggests that this list include payer representatives for each initiative the practice participates in.

To improve understanding of "SIM payment support," the team created a podcast (http://bit.ly/payerpodcast) on the topic, a SIM video (http://bit.ly/payment-support-SIMcohort) that highlights payer participation and the resources noted above. In AY4, the team will continue its work to inform practices that SIM does not offer one payment model and that payer support in SIM does not necessarily mean that the practice will receive a different type of reimbursement from payers. The team has also highlighted—and will continue to do so—the value of using data in more effective ways when it is time to renegotiate contracts with payers. This will continue in AY4, and the Multi-Stakeholder Symposiums will feature cohort-1 practices and the ways in which the work they've done in SIM will set them up for future success when negotiating with payers. One of the most valuable aspects of SIM is the guidance practices receive—and access to the data aggregation tool—which helps them collect, report and use

data in ways that show how changes in process and patient interactions can reduce costs and improve health outcomes. What the team will focus on in AY4 is helping SIM practices communicate that work—and those success stories—to payers.

Collaborating with payers

The SIM team continues to evaluate the model and work with the Multi-Payer Collaborative (MPC) to ensure that payers understand the work involved in practice transformation efforts to help pave the way for better communication between payers and providers and improve the likelihood of better discussions about what work might warrant additional payment from a payer's perspective.

During this process it became evident that while cohort-1 milestones were comprehensive, they were too expansive. With no accountability metrics or goals, and an expansive list of activities across 10 building blocks, it was hard for practices to focus their efforts and for payers to see how SIM participation influenced transformation that resulted in better patient outcomes and reduced or avoided health care costs. To rectify the issue, the team worked with the MPC to simplify the SIM Framework using the "Bodenheimer Building Blocks of High-Performing Primary Care," aligning with the Comprehensive Primary Care Plus (CPC+) initiative along with others and identifying goals with milestone metrics for each year of SIM participation. This allows practices and payers to move forward with a shared understanding and expectation of practice-level achievements in SIM and paves the way for mutually-beneficial discussions about how practice transformation efforts benefit practices, payers and patients.

The payers also identified a high-level framework that outlines SIM payer support in Colorado and amended the memorandum of understanding (***Appendix D3***) to include descriptions of each payer's alternative payment model (APM) for SIM practices. The following is an overview of payer support for SIM:

Payers that support SIM have agreed to apply organization-specific payment model(s) and establish their own agreements with practices selected for SIM. Payers have APMs in place with many practices in their networks to support primary care transformation. As noted in the SIM MOU addendum, the payers in Colorado have adopted the Health care Payment Learning Action Network (HCP LAN) payment category framework (***Appendix F2***).

Payers' existing APMs are tied to performance measures and they will continue to work collaboratively in AY4 to align measures that support behavioral health integration. Additionally, there is payer support for the SIM clinical quality measures and claims-based measures that help practices identify how their efforts affect health care quality, utilization and costs. The SIM office recognized the need to evaluate and align its CQMs with innovation programs in the state and a simplified and aligned measure set (***Appendix B1***) was developed with stakeholder input and approved by the payers. Despite the commitment to the SIM measurement set, there continues to be a reporting burden on practices that must report measures that are not included in the simplified measure set, and this is recognized as an area of focus moving forward.

Participating payers have aligned their expectations with the SIM Practice Transformation Building Blocks. While each payer uses its own payment model to support SIM's transformation goals, the payment model(s) include the following basic elements:

4. Fee-for-service payments;
5. Payments that include behavioral health integration through one of the following mechanisms:
    a. Upfront payments;
    b. Population-based payments (e.g., PMPM);
    c. Care coordination payments; or

   d. Payment for additional codes.
6. Shared savings opportunities OR incentive payments based on performance and/or outcomes linked to quality.

Additionally, the MPC will continue to support a data aggregation tool (Stratus™) to help practices understand care gaps and utilization patterns. The data sharing tool helps practices assess cost and utilization data and risk stratify patients in ways that improve delivery of care and reduce or avoid costs. The SIM team will continue to develop different ways to highlight how this tool helps practices identify opportunities to interact with patients differently and identify are unique value to health plans, which can be used in contract negotiations.

Providers often receive multiple reports from each health plan they work with and must log on to several websites to access patient data. One of the most valuable marketing messages from Best Doctors, the company that owns Stratus™ is that this tool allows providers to access patient claims data from one website. Best Doctors partnered with Colorado's Center for Improving Value in Health care, other state and local entities, and participating payers to build the tool and help ensure a comprehensive approach to data aggregation. During AY3, SIM re-procured the data aggregation tool to support SIM practices, including those in cohort 2, which began in September 2017. SIM will continue to support cohort 1 practices with the data aggregation tool and will continue to develop ways to encourage practices to use the tool in AY4.

SIM cohort-3 practices start their work in the summer of 2018. The selection process included payers, which identified the practices they would support in this last cohort. The expectation is that practices that participate in SIM, and advance through components of the model, will greatly improve their likelihood of being successful in value-based payment models. The MPC will continue to focus in AY4 on sustaining the advances in behavioral health integration through ongoing practice support and alignment across initiatives. Many of the payers have internal quality improvement teams that have been increasingly engaged in the MPC to ensure alignment across expectations and support for the practices. A shared understanding of the challenges and opportunities to support practices has emerged. This will help ensure the continued support that the payers provide practices after the SIM initiative builds off of the SIM building blocks in terms of principles and milestones of success.

To ensure that the MPC discussions are high-level and warrant attendance from health plan executives, the group formed workgroups to discuss payer data use, practice data engagement and quality measures. In AY4, the SIM team will continue to participate in these groups as needed and use information shared to inform Stratus™ communication and education. The SIM team will also continue to foster effective communication between payers and providers in AY4.

Self-funded plans and employer purchasers

The SIM office continues to reach out to self-insured employers and purchasers to gain perspectives on how the team can engage with this group and educate health care purchasers about how whole-person care can improve outcomes and reduce costs. Ongoing work with the Colorado Business Group on Health (CBGH) has identified the need to help self-insured "buy better health care" instead of more health care, an ongoing goal for the CBGH. After presenting to this group in the past and attending monthly meetings, the team realizes the need to show more data as it becomes available (and is approved for external use) that shows how integrated care improves health and reduces or avoids health care costs, improves presenteeism and other benefits that will appeal to self-insured employers. The first presentation resulted in requests for SIM providers in their areas, and the SIM team has several other presentations planned for AY4 that should increase this interest in SIM practices. The team is also talking about ways to add to and highlight a list of integrated health care practices in the state (including SIM practices) that would continue to be available after the SIM team completes its work in July 2019.

From a statewide perspective, there are 275,000 self-funded "lives" in the APCD. For statewide context, data published by the Kaiser Foundation and the Department of Insurance in 2016 shows that there were 1,235,218 lives covered by self-insured employers at that time.

Leverage MPC and multi-stakeholder symposium

The Colorado MPC includes public and private health care payers working to strengthen primary care. Established in the spring of 2012, the MPC originated as part of the Centers for Medicare and Medicaid's Comprehensive Primary Care (CPC) initiative. At its inception, the MPC included 10 payer organizations, regional and national as well as public and private, that coordinated efforts and supported CPC practices. The MPC now includes six payers operating in Colorado. It is committed to building on initial efforts to expand and support primary care transformation throughout Colorado, and is focused on supporting SIM, CPC+, and regional data aggregation. Not all payers participate in each project supported by the MPC, but all payers are committed to payment and practice transformation in Colorado. Membership includes:

- Anthem Blue Cross/Blue Shield of Colorado
- Centers for Medicare and Medicaid/Center for Medicare and Medicaid Innovation
- Cigna
- Colorado Department of Health Care Policy and Financing
- Kaiser Permanente
- Rocky Mountain Health Plans
- UnitedHealth care

The MPC uses the following definition of success to guide its work: *A shared commitment to increased quality, improved efficiency, higher value, and continuous improvement and diffusion of innovative and successful strategies through increased system accountability, improved health outcomes and experiences for patients and providers, and decreased total cost of care.*

The Multi Stakeholder Symposium (MSS), which is held three times a year, provides an opportunity for practices, payers, and practice transformation organizations (PTOs) to build closer partnerships, reflect on progress made to date, and get updates on the SIM and CPC+ initiatives. Our most recent MSS occurred on April 26th and was the second meeting to include SIM cohort-1 and cohort-2 practices. It was the first to include CPC+ practices in the second half of the day.

Relationship between the MPC and SIM

The MPC serves as the primary forum for SIM's engagement with public and private payers throughout the implementation of the model test. However, in AY4 the SIM office will continue to engage with payers and other stakeholders outside of this setting to inform and direct payment reform activities.

Service delivery models

The Colorado State Innovation Model (SIM) has committed to improving access to integrated physical and behavioral health care services in coordinated systems, with value-based payment structures, to 80% of Colorado residents by 2019 through these mechanisms:

- Providing direct practice transformation support to approximately 300 primary care practices during the implementation period;
- Supporting a Bi-Directional Integration Demonstration Pilot that will create integrated health homes in four community mental health centers (CMHCs);
- Investing in local public health agencies;
- Acting as the primary funder to create a new health care workforce in the form of regional

health connectors; and

- Exploring ways the initiative might be able to provide indirect support to the Veteran's Administration, Indian Health Services and school-based health clinics.

The SIM practice transformation and service delivery stakeholder workgroup continues to provide guidance on all aspects of practice transformation by providing thought leadership, promoting synergy with payment reform efforts, and ensuring alignment with other components of the initiative.

Practice transformation in the primary care setting

Status of practice transformation cohorts:

The SIM office has selected three cohorts of primary care practices for inclusion in the direct service practice transformation activities during the three-year period:

- Cohort 1: 92 practices participated; two years of direct practice transformation support;
- Cohort 2: 153 practices participating; two years of direct practice transformation support; and
- Cohort 3: 89 practices accepted; one year of direct practice transformation support.

The SIM office continues to contract with the University of Colorado Department of Family Medicine (UCDFM) to manage the practice transformation organizations, which lead practice transformation efforts in SIM practices across the state.

Cohort 1—background

The SIM office selected 100 primary care practices to join the first SIM cohort in December 2015, and primary care practices began transformation efforts in March 2016. A total of 92 of the original 100 practices in cohort-1 completed the program. Five of the eight practices were acquired by a national health care system and the internal quality improvement process precluded them from participating in SIM. The other three practices withdrew for a variety of reasons, including what practice representatives believed to be insufficient support from payers and changes in practice leadership that reduced practice capacity for participation. Six of the eight practices that withdrew were accepted into Comprehensive Primary Care Plus (CPC+). Cohort 1 ended their official participation in SIM in March 2018 with all 92 practices completing the two years successfully. The SIM office will continue to provide indirect support through access to ongoing training, conferences and resources and cohort-1 practices continue to be engaged in the initiative. The Multi-Stakeholder Symposium in April will feature two practice teams that will present information about their work in SIM. The goal is to engage cohort-1 practices in discussions about how their work can be communicated with payers to highlight their work, the importance of effective communication with payers and to encourage ongoing collaboration between cohort practices.

Practice satisfaction survey results

UCDFM conducted a practice satisfaction survey with cohort-1 practices after one year of participation in the initiative to solicit feedback regarding levels of satisfaction with the initiative and the support from practice facilitators (PFs) and/or clinical health information technology advisors (CHITAs) through their practice transformation organizations (PTOs). UCDFM repeated this survey for cohort-1 practices near the end of their second year of SIM participation. The semi-structured satisfaction survey consisted of 15 questions. All questions, except for the unstructured items, were required. The survey was sent to key individuals in each of the 92 cohort-1 practices and yielded the following results:288 responses were received across 60 (65%) of the 92 SIM practices;

- 96.5% of respondents agreed/strongly agreed that PFs helped them accomplish practice goals;
- 91% respondents agreed/strongly agreed that CHITAs helped them accomplish practice goals;
- 94% of respondents stated that they would recommend SIM participation to a colleague and/or

other practice;

- 6% of respondents) said they would not recommend SIM participation for these reasons:
    - CQM reporting burden (2 respondents)
    - Did not advance clinic transformation (1 respondent)
    - Lack of leadership and communication (1 respondent)
    - Lack of direction overall for the program including specific assistance for smaller practices (1 respondent)
    - The burden of participating in multiple practice transformation initiatives (3 respondents)
    - Payment was insufficient to support the effort (7 respondents)
    - Inadequate support from the PF and/or CHITA (1 respondents)
- Responses to an open-ended item regarding advantages and value of SIM included:
    - "Seeing increased integration of behavioral health and other support staff into our clinic, which in turn has resulted in better care of patients";
    - "Being part of an effort/mission greater than our own";
    - "The chance to network with other [practices] integrating behavioral health… SIM [has] continued our efforts for practice transformation to further prepare us for value-based payment system"
    - "Structured work on getting the most accurate data"
- Responses to an open-ended question regarding implementation challenges included:
    - "Working with health plans in credentialing the licensed clinical social worker. The reimbursement rate for behavioral health"
    - "Buy in from other staff in our office."
    - "Start up and sustaining the cost of behavioral health integration."
    - "Sophisticated business support to better understand value-based reimbursement models."

The SIM office used the initial survey feedback to improve its practice transformation model for cohorts 2 and 3, as described in the sections below, and the team will use the cohort-1 closeout survey.

Cohort 2

The SIM office delayed release of the request for applications (RFA) for cohort 2 from summer 2016, as originally anticipated, to February 2017. This decision was made based on several factors, including:

- Timing with release of CPC+ applications: The delayed release of the SIM RFA avoided a conflict with the open application window for CPC+. The team received feedback from key stakeholders that applying to two Centers for Medicare and Medicaid Innovation (CMMI)-funded initiatives concurrently might be overly burdensome for practices and create confusion. Additionally, the SIM office needed time to work with CMMI leadership to determine how to align the two initiatives.
- Alignment with No Cost Extension (NCE): Due to the budgetary and programmatic implications of the six-month NCE, the SIM office delayed the start of practice transformation efforts for cohort 2 until Award Year 3 (AY3).
- Improvement of the model: After gathering feedback from cohort-1 practices and stakeholders, the SIM office delayed the cohort-2 RFA to refine the practice transformation model.

The RFA for Cohort 2 was released Feb. 16, 2017 (https://www.colorado.gov/healthinnovation/cohort2), and we received 226 applications by the close of the application March 31, 2017. The SIM office selected 165 practices to participate, and 155 signed the practice participation agreement. The cohort began its work in September 2017 and will continue through July 2019 for 22 months of direct practice transformation support. The RFA included

several key changes from cohort 1 that were made based on stakeholder feedback to improve the experience of cohort-2 practices and maximize the effects of the model.

Feedback	Change to Cohort 2
Reporting burden too high	Streamlined set of Clinical Quality Measures (CQMs)
Difficulties implementing SIM at individual practice sites instead of across groups/systems	All practices in a group/system are now encouraged to apply
Confusion regarding support from payers	Inclusion of clarifying language plus links to the payer Memorandum of Understanding (MOU), addendum, and payment model summaries are published in the RFA
$5,000 insufficient/$40,000 grants were difficult to apply for	Achievement based payments of up to $13,000 will be available, and additional grant funds will exclusively be provided via The Colorado Health Foundation
Insufficient Health Information Technology (HIT) support	Inclusion of Health Information Exchange (HIE) support in RFA, more clearly defined information regarding broadband expansion. (See HIT section for more information)

Cohort 3
The RFA for cohort 3 was released Nov. 15, 2017, and closed Jan. 19, 2018. There were 90 applications and 89 were accepted for participation. The practice that was not accepted did not meet the primary care definition. The SIM office confirmed payer support and will contact practices in early May 2018, about their acceptance. Cohort 3 is on track to begin June 29, 2018.

Revised practice transformation building blocks:
SIM adopted a building block model based on Dr. Thomas Bodenheimer's conceptual framework of the "Building Blocks of High-Performing Primary Care" to advance change. 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.

Cohort-1 practices received a set of activities associated with the 10 building blocks and chose which milestones to work on based on their priorities that were outlined in practice improvement plans. The SIM office received feedback that, while this approach provided ample flexibility it did not provide clear guidance regarding the number and type of activities practices had to achieve to be successful in SIM. Additionally, variance in practice activities made it difficult to evaluate the effects of the model. Finally, the SIM office recognized the need to ensure that activities were aligned with payer priorities.

As a result, the SIM office worked with members of the Multi-Payer Collaborative (MPC) to revise activities associated with the building blocks and create a SIM framework and milestones used by SIM cohort-2 and -3 practices. The SIM framework includes a set of adult and family milestones as well as a set of pediatric milestones that are appropriate for practices serving only pediatric patients. Cohort-1 practices were not required to adopt the new framework though they were encouraged to pick activities within the old framework

that aligned with new milestones identified by payers in the MPC as priorities. UCDFM prepared a building blocks crosswalk (included as ***Appendix F3***) to help cohort-1 practices and the practice transformation organizations (PTOs) that support them identify activities from the revised framework that map to the cohort-1 framework.

Practice sites in cohorts 2 and 3 are expected to maintain “good standing” with the behavioral health focus of the initiative through successful completion of identified building blocks and achievement of key milestones in the SIM framework. If practice sites are not in good standing, payers will determine how that affects their programs and the payment a practice receives. The SIM office will work with PTOs and UCDFM to support transformation and to determine a practice site’s standing. Practice standing information will be shared with payers to inform practice eligibility for payment.

The SIM office, in conjunction with UCDFM, updated the SIM Implementation Guide and Toolkit (www.practiceinnovationco.org/sim/simimplementationguide/) to provide practices with resources and supports to advance through the milestones based on the revised framework. Key assessments were revised to capture progress made by practices in the new framework, which were implemented in AY3 and will continue in AY4. For example, while cohort-1 practices used a practice improvement plan, cohort-2 and cohort-3 practices will use a Milestone Attestation Checklist instead.

Behavioral health integration:
Behavioral health integration is a key component of SIM, as reflected by building block 10 of the framework referenced above: “Practice has fully integrated behavioral health care to provide whole- person care.” In addition to the activities associated with building block 10, activities that promote integration are woven throughout the building blocks (for example, the goal of building block 7 states that the “practice screens at least 90% of patients for substance use disorder/other behavioral health needs; includes behavioral health and community services as part of care management strategies.”)
Each practice completes the Integrated Practice Assessment Tool (IPAT) at baseline and periodically throughout the initiative to gauge progress. Practice facilitators (PFs) use the tool in conjunction with an assessment of where practices are with implementing the SIM framework and milestones to complete practice improvement plans in cohort-1 and the Milestone Attestation Checklist for cohort-2 and cohort-3 practices.
Recognizing that some practices are farther along the pathway of achieving fully-integrated care than others and that each practice has unique needs, the SIM office aligned its support with the Comprehensive Primary Care Plus (CPC+) Behavioral Health Integration Menu of Options so practices can focus on care management for mental illness or the primary care behaviorist model.

Technical assistance to practices:
Practices in all SIM cohorts will be provided with technical assistance and support via four avenues:

- In-person facilitation and assistance
- Collaborative Learning Sessions
- E-learning modules
- Webinars

In-person facilitation and assistance
Practice sites are provided with a PF and a clinical health information technology advisor (CHITA) as well as linked with regional health connectors (RHCs) to deliver a comprehensive, personalized package of in-office support that helps them achieve the SIM framework and milestones and connects them with community and state resources. The PF and CHITA are provided by one or more of the practice transformation organizations (PTOs) selected by a rigorous procurement process to ensure that practices benefit from highly-skilled personnel. Currently, 17 contractors provide PTO services. The broad range of PTOs was intended to ensure that practices in all sections of

the state have an adequate number of options to choose from (as some PTOs work in specific areas of the state) and allow practices the opportunity to work with organizations that previously offered them practice transformation support. Because the number and reach of PTOs was sufficient for Cohort 1, the SIM office did not recruit more PTOs for cohorts 2 and 3. RHCs are deployed through local organizations selected for their trusted relationships in the communities they serve see plan for improving population health section for more information). An overview of each role is provided below.

1. PF role:

   a. Support implementation of an ongoing change and quality improvement process through quality improvement teams;

   b. Contribute to the development and updating of a SIM practice improvement plan or Milestone Attestation Checklist;

   c. Facilitate quality improvement team activities to focus on objectives;

   d. Identify and help resolve challenges in achieving objectives;

   e. Provide assistance in translating clinical quality measures (CQMs) and other data improvements into success stories that can be communicated to payers to succeed with alternative payment models;

   f. Facilitate the development of sustainable quality improvement techniques and processes; and

   g. Coordinate and facilitate practice site access to additional practice transformation resources, including coordination with the local RHC.

2. CHITA role:

   a. Assist in the development and updating of a SIM data quality plan (DQA), including identification and assessment of current HIT resources;

   b. Support the enhancement of practice capacity to implement data-driven quality improvement;

   c. Assist with the development and implementation of practice workflow for data collection, reporting, validation and analysis;

   d. Facilitate data-driven quality improvement priorities; and

   e. Link practice sites with technical assistance through various HIT resources (some SIM-related).

3. RHC role:

   a. Provide information about state and regional transformation and community health resources;

   b. Facilitate the connection of practice site to local public health and other community resources; and

   c. Establish ongoing supportive relationships with practice sites that can be sustained beyond the practice transformation support.

Practice Facilitators Quality Improvement Coach Support	Clinical Health Information Technology Advisors (CHITAs) Technical and Data Processes Support	Regional Health Connectors (RHCs) A Trusted Local Convener
• Develop practice leaders who support a culture of improvement • Establish effective quality improvement teams • Identify and solve problems • Link practices to transformation resources	• Support practice data capacity • Analyze and identify ways to improve practice data systems • Optimize workflows for data collection, reporting, and analysis	• Link practices to health care and social determinants of health resources in their communities and across the state • Listen for needs and opportunities • Strengthen community capacity to address local health priorities • Develop relationships among providers, community partners, and local health systems

- All SIM cohort practices work with PFs and CHITAs to accomplish their practice transformation goals and create processes that ensure efficient and effective care delivery. A total of 21 RHCs were hired and deployed. Formal guidelines for how PFs and RHCs can collaborate were finalized. The following adjustments and improvements were made in AY3 to the ways in which these roles deliver support and the team will continue to assess in AY4.

- **Re-scope of the CHITA role:** The SIM office and university developed a core set of CHITA competencies in response to feedback that CHITA support was insufficient, training guidelines were inconsistent, and payment was too low to fulfill expectations. This scope of work was expanded to include a formal assessment of each practice's health information technology (HIT) needs as well as its ability to submit CQMs. This assessment will help to provide greater consistency in how CHITAs identify practice challenges and needs. CHITAs are required to provide documentation of progress made with each practice in relation to the Milestone Attestation Checklist. The SIM office supports the expanded work with increased payment.
- **Addition of Stratus™ support:** As the SIM office rolls out licenses to this data aggregation tool that includes clinical and claims data across payers, PFs are trained on how to support practices with accessing this tool and using it to guide changes in clinical practice. (More information can be found in the HIT section).
- **Connections between practices and other areas:** The SIM office will continue to make connections between SIM-funded entities now that RHCs have been hired, collaboratives of local public health agencies (LPHAs) (see plan for improving population health section) are implementing health systems coordination work. Connections will be made during targeted outreach events across Colorado, via webinars that include multiple partners, and during Collaborative Learning Sessions (CLS) (see below).

CLS

One of the key SIM objectives is to identify best practices and disseminate them as broadly as possible. UCDFM has convened six CLS events, three in the Denver metro area and three on the western slope. Three more CLS events will be held through the SIM initiative, two in the Denver metro area and one on the western slope. During these events, cohort practices, PTOs, bi-directional health homes, and other stakeholders share general knowledge, identify lessons learned, and disseminate best practices. Feedback from rapid cycle feedback reports, as well as the SIM practice transformation and service delivery workgroup, will be used to inform CLS topics.

E-learning modules

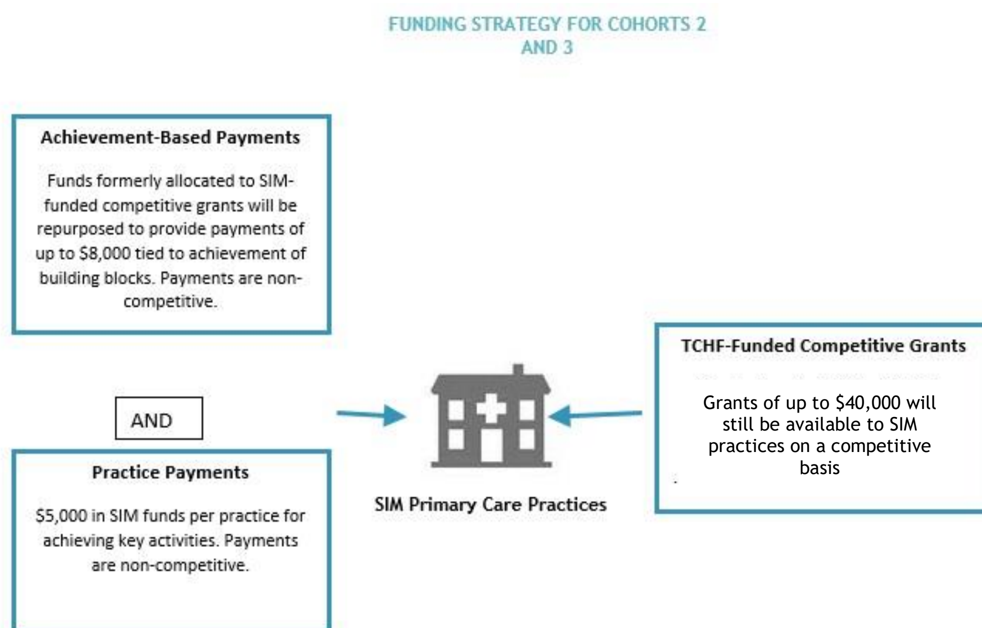
UCDFM developed these modules for its patient-centered medical home e-learning program:

- 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.

E-learning modules were migrated to a new platform in AY3 and disseminated to primary care practices. The Office of Behavioral Health (OBH) has worked with UCDFM on SIM-funded provider education opportunities (see the workforce capacity section for more information) and consolidated platforms to ensure convenient access for SIM practices. Alignment of provider education opportunities will continue to be a key priority for AY4.

Access to capital:

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



Achievement-based payments to practices – Cohort 1

SIM cohort-1 practices qualified for payments of up to $5,000 for completing key activities, such as reporting on CQMs and attending twice-yearly CLS events.

Small grants program

The SIM office created competitive grants of up to $40,000 and established a small grants program, which originally had approximately $3 million in federal funds from CMMI and approximately $3 million in funds from the Colorado Health Foundation (CHF) for all three cohorts. Changes were made to this fund after the SIM office received feedback from stakeholders. The federal funding stream was reinvested in larger achievement-based payments for cohorts 2 and 3, which helps them achieve their transformation goals, and the small grant funding is now limited to the CHF dollars.

SIM small grants – Cohort 1

A request for applications (RFA) for small grants was issued in April of 2016. Practices applied for small grants from a SIM or a Colorado Health Foundation (CHF) funding stream (not both). A total of 66 practices submitted applications, 42 to the CHF funding stream and 24 to the SIM funding stream. A total of 27 practices were selected to receive funds through the CHF funding stream, and 20 were selected to receive funds through the SIM funding stream. The SIM office anticipates disbursing $937,003.00 in grants from the CHF funding stream and $590,766.90 from the SIM funding stream to cohort-1 practices.

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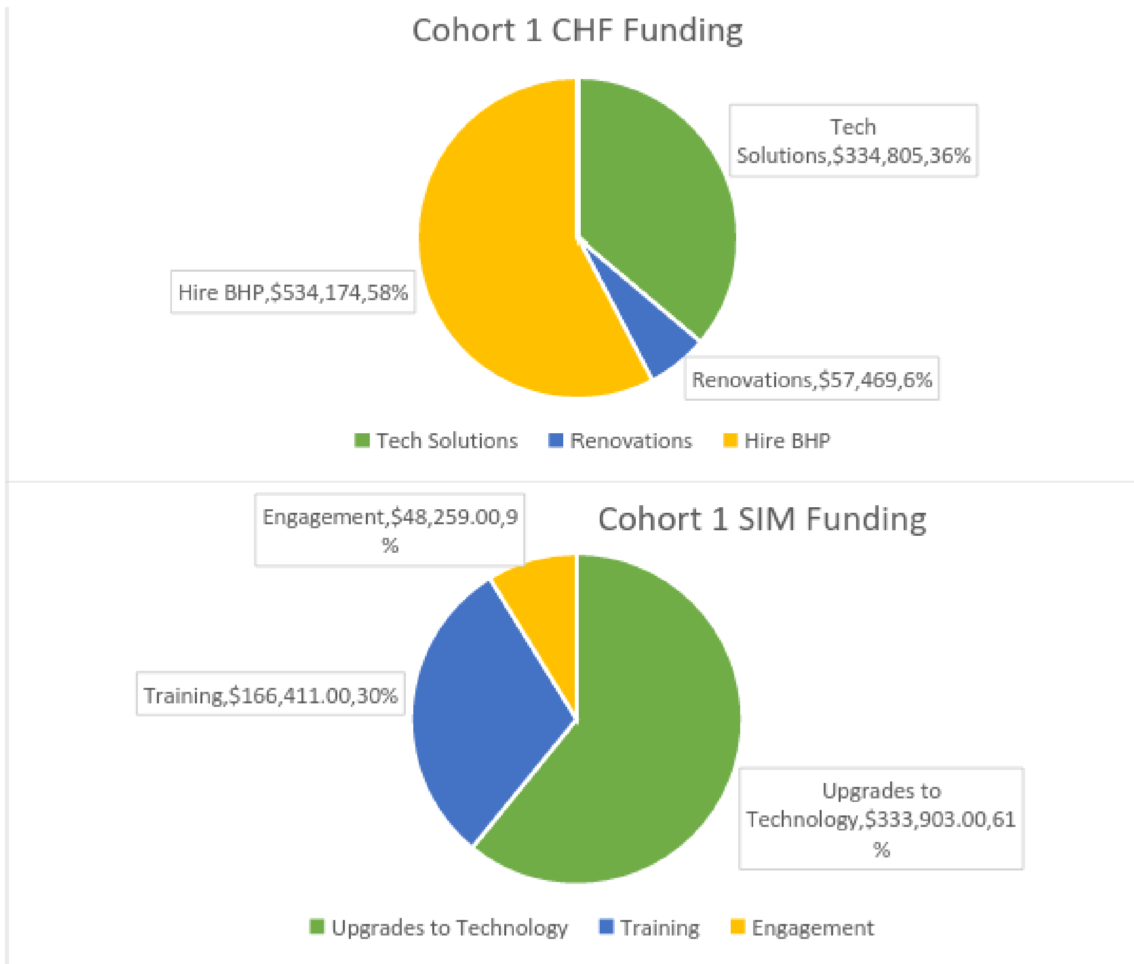
In cohort 1, SIM small grant awardees are using grant funds to (1) train new and existing practice staff (including methods to better coordinate referral to specialty mental health settings), (2) upgrade existing technology to support integrated care, and (3) support methods to foster patient and family engagement in integrated care. CHF grant awardees are using grant funds for (1) seed funding to support behavioral health clinicians, (2) capital costs to support renovations that foster integrated care, and (3) technological solutions to support systematic screening for behavioral health problems. The following charts show the distribution of cohort-1 funding requests from each funding stream:



The SIM small grants manager will continue to support small grant awardees throughout AY4. Practices will submit final reports and outline the impact of grant funds.

Access to capital for cohorts 2 and 3

The SIM office will offer $6,500 in achievement-based payments per year and CHF competitive grants of up to $40,000. In response to feedback from PTOs and practices, the SIM office repurposed approximately $2.4 million of the SIM transformation funds to use for achievement-based payments instead of using the funds for competitive small grants. The non- competitive payments of up to $ 6,500 per year tie directly to a cohort practice's successful completion of activities related to the SIM framework and milestones (See ***Appendix F4***). SIM practices

A table outlining payments to practices in AY4 follows:

SIM Payments to Practice Sites				
Activity	SIM-Only Practice Sites		SIM/CPC+ Practice Sites	
	Year 1	**Year 2**	**Year 1**	**Year 2**
Achievement of Building Block 4 Milestones	$2,000	$2,000	$1,000	$1,000
Achievement of Building Block 7 Milestones	$2,000	$2,000	$1,000	$1,000
Achievement of Building Blocks 8,9, or 10 Milestones (choose one)	NA	NA	$2,000	$2,000
Participation in twice-yearly Collaborative Learning Sessions	$1,000	$1,000	$1,000	$1,000
Quarterly reporting of required measures	$1,000	$1,000	$1,000	$1,000
Participation in the assessments and evaluation activities	$500	$500	$500	$500
Total:	**$13,000**		**$13,000**	

Practice assessments and data driven improvements:
SIM cohort-1 practices complete assessments, which provide evidence of practice progress and provide practices with useful information to help them adjust approaches to achieve their goals. While UCDFM is adjusting certain assessments to reflect the revised SIM framework and milestones for the second and third cohorts and is considering changes to the frequency of reporting, the SIM office expects to use the following assessments throughout AY4.

Practice assessments and data driven improvements:

UCDFM selected a battery of assessments for SIM practices to complete. The assessments are intended to provide evidence of practice progress and to provide practices with useful information to help them adjust approaches to better achieve their goals. While UCDFM adjusted certain assessments to reflect the revised SIM framework and milestones for the second and third cohorts, the SIM office anticipates continuing to use the following assessments throughout AY4.

Assessment Name	Purpose	Timing
Medical Home Practice Monitor	Practice self-assessment of level of implementation of core aspects of advanced primary care.	Baseline & Annually
IPAT (*Integrated Practice Assessment Tool)*	Assesses current methods BHI along levels of coordination, co-location and integration.	Baseline & Annually
Clinician and Staff Experience Survey	Individual provider and staff survey that assesses two subscales – Clinician & Staff Experience, and Burnout.	Baseline & Annually

SIM Milestone Attestation Checklist (previously referred to as Milestone Activity Inventory)	Assesses practice's current implementation of SIM milestone activities, helps identify gaps and prioritizes practice's next steps.	Baseline & Every 6 Months
HIT Assessment (previously referred to as the Data Quality Assessment)	Assesses practice's current state of data quality including accuracy of data element capture, validity of CQM reports and desired next HIT steps.	Baseline & Every 6 Months
Clinical Quality Measures	Track patient and process outcomes achieved by practices.	Every calendar quarter

Additional information about data-driven improvements used by practices, prompted by use of the Stratus™ tool and cost and utilization reports, is provided in HIT section and within the program monitoring and reporting section.

Quality Assurance:
Starting in AY2, UCDFM convened a Quality Assurance Committee, which continues to meet on a bimonthly basis to discuss and monitor progress among primary care practice sites and PTOs. This committee mapped out a process for identifying and addressing primary care practice sites and PTOs that might not be meeting expectations (see ***Appendix F5***). In addition, this committee has begun to identify practice sites that have improved or remained consistently high performing in a few metric areas. Current foci include CQM reporting and will also include the Milestone Attestation Checklist (MAC) once the six-month follow-up data for this assessment is available. This process will continue throughout AY4 and this committee will continue to build and refine a practice and PTO dashboard through AY4 that flags potential issues in implementation and identifies practice success stories.

While the Quality Assurance Committee is not convened by the SIM office, the SIM program implementation manager and the SIM data lead coordinator sit on the committee. Coordination of data and sharing of committee findings regularly occurs with the SIM team. These findings are used to identify successes and challenges within the initiative. Furthermore, workgroup chairs are aware that this committee is available to examine issues in greater detail that may be identified by each workgroup. Committee documents are shared with SIM staff. In this manner, the Quality Assurance Committee is incorporated into the SIM governance and decision-making structure.

In AY3 and AY4, the SIM office will submit regular reports to payers regarding which SIM cohort 2 and 3 practice sites are not in "good standing." Practice standing will be gauged by progress through the priority milestones, as outlined in the SIM framework and milestones (see ***Appendix F4***). The SIM office and UCDFM drafted a process for attesting to practice standing and vetted it with members of the Multi-Payer Collaborative.

Patient engagement:
Patient engagement is a key component of the SIM model. Milestone Building Block 5: "Practice has built partnership with patients" includes use of shared decision-making aids in practices as well as quarterly Patient Family Advisory Council meetings as key activities. In AY4, UCDFM will continue to collect data on milestone progress through the Medical Home Practice Monitor assessment and Milestone Attestation Checklist.

Resources from the SIM Implementation Guide help practices achieve milestone 5. Trainings presented at CLS events will continue to focus on patient engagement during AY4. The SIM office worked with key stakeholders to determine an experience of care measurement for the initiative, which will be used in AY4. Work continues with the state-led evaluator and other partners to determine the best approach. In addition, the Consumer Engagement workgroup has taken a more active role in providing feedback to the university and PTO and will provide a platform for consumer and patient engagement input. For more information about the experience of care measure refer to the program reporting and monitoring section.

Alignment with CPC+:
A large number of practices that applied to SIM in cohort 2 and cohort 3 are also CPC+ practices. Recognizing this substantial overlap, the SIM office continues to seek ways to increase programmatic and operational alignment between SIM and CPC+ that help minimize provider burnout and frustration. In AY2, the SIM office developed an alignment strategy and engaged in robust conversations with a wide range of stakeholders, including providers, payers, and practice transformation experts. Stakeholders agreed to seek a strategy that would:

- Maintain the multi-payer focus of the SIM initiative;
- Ensure diversity in the type of practices engaged in SIM;
- Reduce the burden on practices that might want to participate in both initiatives; and
- Preserve SIM's unique focus on the integration of physical and behavioral health.

The consensus was that the interrelated goals and objectives of SIM and CPC+ create natural synergies and a true benefit for practices, providers, and payers electing dual participation. This mitigated the risk of practices choosing between the two initiatives and accentuated their complementary nature. The vision of alignment coordinated practice requirements, such as practice transformation support, learning collaborative offerings, and quality measure reporting to reduce provider burden and preserve SIM's focus on the integration of physical and behavioral health, coordination of primary care, public health and community health organizations. More detail about alignment of the two initiatives, and the work completed by the SIM team to ensure there is no duplication is included in **Appendix K1.** In AY4 the SIM office will maintain these areas of alignment and pursue other ways to align with CPC+ and other initiatives in the state. The SIM office differentiated requirements for cohort-2 and cohort-3 practices in SIM and in CPC+ and SIM:

<table>
<tr><th colspan="2">SUMMARY OF SIM PARTICIPATION EXPECTATIONS</th></tr>
<tr><th colspan="2">Shared Expectations of All SIM Practice Sites</th></tr>
<tr><td colspan="2">1) Identify a cross-functional quality improvement team to implement improvements based on the SIM Practice Transformation Building Blocks.

2) Complete a set of practice assessments to identify key areas of focus for improvement.

3) Participate in SIM evaluation activities.</td></tr>
<tr><th>Expectations of practice sites in SIM-Only</th><th>Expectations of practice sites in CPC+ and SIM</th></tr>
</table>

4) *Required* to attend the SIM CLS events. 5) Collect, report, and review SIM Clinical Quality Measures on a quarterly basis. 6) Complete a foundational subset of building blocks through achievement of key milestones.	4) *Encouraged* to attend the SIM CLS *but not required to do so.* 5) Collect, report, and review *only the* SIM Clinical Quality Measures *that align with CPC+ requirements* on a quarterly basis. 6) Complete an advanced subset of building blocks through achievement of key milestones. *** Practice sites in CPC+ and SIM will be expected to adhere to all expectations of CPC+*

During AY4, the SIM office will continue conversations with the CPC+ team to ensure alignment of key areas including delivery of practice transformation support and the timing and content of CLS events.

Practice transformation in bidirectional health homes

To improve care and reduce or avoid unnecessary health care costs, care integration should occur within primary care settings that patients identify as their primary locus of care. Community behavioral health settings are an excellent example of locations where patients feel most comfortable, including populations with severe, co-occurring mental health, substance use disorders and chronic health conditions. To ensure an inclusive approach, SIM contracted with the Colorado Behavioral Healthcare Council (CBHC) to facilitate and manage an initiative that supports integrated health homes within four community mental health centers (CMHCs).

In 2015, CBHC selected four CMHCs to participate via an independently managed, Request for Proposal (RFP) process that was based on a vision and activities articulated in the original SIM application and concept documents. All sites are operational and a description of how CMHCs are using SIM dollars to support bi-directional integration, which will continue in AY4, follows:

Community Reach Center (CRC) is a private, nonprofit community mental health center in the north Denver area. For the bi-directional pilot program, CRC is partnering with Salud Family Health Centers, a Federally Qualified Health Center (FQHC) serving communities in northeastern Colorado, and Dental Lifeline Network. CRC and Salud Family Health Centers placed a fully functional medical clinic in CRC's Commerce City Outpatient Clinic in December 2014. SIM funds are used to transform this clinic into a fully integrated health home with the goal of serving 1,200 patients with a focus on those who have severe mental illness and high health needs. SIM funding supports several new activities that are crucial to advancing integration of behavioral and physical health care at the site, including use of feedback-informed treatment, which comprises an outcome rating scale and session rating scale to guide patient care. Through this process, information will be shown to consumers, who will see a graph in the EHR to put them "in the driver seat" of their care. CRC will adopt the Four Quadrant Clinical Integration Model from the Substance Abuse and Mental Health Services Administration to improve care coordination: www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/four-quadrant-model.pdf.

Jefferson Center for Mental Health (Jefferson Center) is a private, nonprofit community mental health center serving Jefferson, Gilpin and Clear Creek counties. Jefferson Center is partnering with Metro Community Provider Network (MCPN), the local federally qualified health center to develop the Jefferson Plaza Family Health Home (JPFHH). JPFHH is the third in a series of shared, integrated health homes between the three partners. SIM funds build on the existing health home infrastructure to move beyond co-location and advance the level of bidirectional integration and cross-organizational system transformation and culture change in pursuit of a sustainable model of

bidirectional integration that effectively achieves and demonstrates quadruple aim outcomes. Jefferson Center has a long history of partnership with these agencies, and JPFHH is a new endeavor that aims to serve 3,000 patients by AY4 with a focus on children, adolescents, young adults, homeless families and individuals, and individuals with severe mental illness and high health needs. SIM funds support increased levels of coordination between partners, new processes and procedures to ensure coordinated care, and preparation for a shift to value-based payment.

Mental Health Partners (MHP) is a private, nonprofit community mental health center that has provided mental health care for more than 50 years to the local underserved population in Boulder and Broomfield counties. With SIM funding, MHP is partnering with Clinica Family Health Services, the local FQHC, and Dental Aid, to create Boulder Health Integration Partners (BHIP), a multi-agency collaborative partnership. This partnership is developing an integrated health home that proposes to serve 1,000 patients by AY4 with a focus on those with severe mental illness and high physical health needs. Because the site endeavors to reach underserved patients in the community, who do not access care, and will be conducting outreach to populations and incorporating new services into the health home, a SIM-funded full-time-equivalent position will be exclusively devoted to completion of new activities that advance SIM programmatic goals, not to support existing operations.

Southeast Health Group (SHG) is the private, nonprofit community mental health center providing mental health, substance use, primary care, and wellness services to the six-county, rural and frontier region in the southeastern corner of Colorado. SHG will use SIM funding to support the creation of an integrated health home model in two of its practice sites (Rocky Ford and Lamar) and to expand existing bidirectional services at its La Junta site. Establishing a health home model in two new sites requires new processes and procedures, training additional staff, tailored outreach to distinct communities, and resources designed to meet the unique needs of patients at each site. Other organization-wide changes anticipated include modifications to SHG's EHR that will support integrated care, improved tracking of pain management patients and increased training on Suboxone treatment.

CBHC conducts annual site visits as part of their support and oversight of the CMHC's. The SIM Program Implementation Manager was able to join them on those site visits in the fall of 2017. Each site shared successes of the bi-directional work so far. For example, three of the CMHC's are partnered with a Federally Qualified Health Center (FQHC) and those partnerships are going well. Leadership from both agencies continue to meet regularly and work out any challenges that arise. They also reported that SIM dollars have allowed for creativity in developing new ways to provide care including a navigation position, group work with patients and additional support for OUD/SUD.

Of course, there have been some challenges along the way. Payment structures are different for behavioral health and physical health, even within the new RAE structure. Several of the services they provide, such as peer support and case management, are not covered by insurance and there are no revenue sources that pay for them. They have also learned, across the board, that 20-minute physician visits are not feasible in a bi-directional health home due to the complexity of patient needs with the SPMI (severe persistent mental illness) population. All four sites have moved to 40-minute visits with their patients. This is great regarding the care the patient receives, but difficult regarding payment, as they cannot see as many patients per day as primary care settings.

Along with the rest of Colorado SIM, all four CMHC's will have a focus on sustainability in this final year. The CMHC's will be exploring ways to connect more to primary care providers in their communities regarding accepting patient referrals, especially given the Behavioral Health Provider shortage within the state. The CMHC's will each be creating a template designed to provide guidance to other CMHC's, both inside and outside of the state, on how to become bi-directional. There will be four distinct templates, as each of the four CMHC's has a unique approach.

The SIM Program Implementation Manager will join CBHC for site visits again in the fall of 2018, beginning with Southeast Health Group in La Junta, Colorado in September. The CMHC quarterly meeting will also occur at that time.

CBHC will continue to provide support to the four sites and practice transformation vendors in AY4. It facilitates regular phone calls between sites and create other opportunities for peer-to-peer learning such as quarterly in-person collaborative visits. CBHC will also provide technical assistance to sites, conduct site visits and report successes and challenges to the SIM office. The SIM office has asked for monthly updates on successes to highlight in publications. CBHC will continue to maintain and manage all contracting and subcontracting processes related to the bi-directional program. During AY4, CBHC staff will maintain close involvement with the broader SIM initiative to ensure alignment. AY4, CBHC staff will continue to maintain a strong presence and engagement with the SIM workgroups, steering committee and advisory board.

Alignment with practice transformation efforts in primary care

In AY4, each CMHC will continue work with its assigned PF and Clinical Health Information Technology Advisor (CHITA). The services are similar to the scope for the broader cohorts of primary care practices in SIM, creating alignment between the activities and milestones for these different models and settings of integrated care. In AY4, health home sites will continue to participate in CLS events described in the section above and the Multi-Stakeholder Symposiums. The sites also participated in and helped to drive two CLS events for the CMHCs. Sites will continue to participate in these activities in AY4 to learn from and share best practices with primary care sites.

Measuring impact

Recognizing that CMHCs have different capacity and needs than primary care practices, the SIM office contracted with Health Management Associates (HMA) during the AY2 NCE to recommend data collection and reporting strategies and to identify a uniform method of consistently reporting attribution, clinical quality measures, and participating providers. HMA conducted focus groups with all participating sites as well as TriWest, the SIM office, and other key stakeholders. Based on information gathered, HMA drafted, prepared and presented a guidance document (see ***Appendix F6***) to the SIM office with specific recommendations and action steps for data collection, which are now being followed. Participating sites began collecting this data based on the recommendations in the guidance document in AY3 and will continue to submit data per this guidance document in AY4.

b. Quality measures alignment

As SIM cohort-1 practice sites reported clinical quality measures (CQM) data during the first year of implementation, the SIM office received feedback from practice representatives and CHITAs about challenges with CQM reporting. The biggest challenge is working with electronic health record (EHR) vendors to build the necessary data fields and reports to capture and report CQM data and will require a longer-term strategy. The SIM office made significant changes to reduce reporting burden and align with other initiatives.

The SIM office is also working with the governor's office to establish a different type of partnership with EHR vendors that agree not to charge SIM practices extra for reporting CQMs that are required for the initiative as well as the other initiatives in the state that are listed on the CQM alignment (TCPi, CPC+, QPP, Medicaid APM). The request also enlists EHR vendor partnership with the SIM electronic clinical quality measure (eCQM) solution. The request to vendors is that they not charge practices that participate in this, new eCQM solution, which will allow practices to have the information automatically extracted once and reported to several, approved entities. More information about the eCQM solution is included in the HIT section of the report. The SIM team will share the EHR letter to vendors with CMMI once it has been finalized.

Measurement period

In AY4, the SIM team will continue to assess the work that was completed with key stakeholder partners and CHITAs to change the measurement period for SIM CQM reporting. Moving forward, SIM practice sites will still report on a quarterly basis to have real-time, actionable data that informs internal quality improvement efforts, but a quarterly (90-day) lookback period for CQM reporting is not feasible and does not produce trustworthy data for most practices. Different EHR vendors and versions have different capabilities, and there is not one common measurement period methodology across all systems. The SIM office provided guidance to practice sites to report CQMs using a rolling 12-month measurement period. If that methodology is not available, practice sites are encouraged to use a year-to-date measurement period. There are a few cases in which neither a rolling 12-month nor a year-to-date methodology are available, and practices used a quarterly lookback period.

Simplified CQMs

In AY4, the SIM office expects to see benefits from its work to simplify the CQM measure set (see ***Appendix B1***) that practices are required to report. There are now fewer CQMs that are required, and some measures were prioritized as "primary" CQMs. In addition, the group (the SIM office with input from UCDFM partners, CHITAs and key stakeholders) identified target areas where SIM could move the needle over time and developed a more focused measure set for practices in January 2017. Cohort-2 practice sites are required to phase-in primary measures during their first year of SIM participation. Cohort-3 practice sites will be required to report on the full primary measure set once they begin SIM participation, due to the shorter time period for participation. If practices in either cohorts 2 or 3 cannot report on a given primary measure it can be replaced with a secondary measure to meet requirements. A practice team is expected to work with its CHITA to report all primary measures over time. Practice sites are encouraged to report on primary and secondary measures during their SIM participation.

The simplified CQM measure set also applies to the community mental health centers (CMHCs). All four CMHCs will report on the six measures in the adult "primary" measure set every quarter. If a CMHC is unable to report on one or more of the primary measures they can be replaced with secondary measures to meet the requirement. One CMHC has elected to report on the "primary" pediatric measure set in addition to reporting of the "primary" adult measures.

CQM alignment

The SIM office ensured that all measures within the simplified CQM set aligned with existing initiatives (CPC+ and TCPI), the Health Care Policy and Financing (HCPF) alternative payment model (APM), and the Quality Payment Program (QPP). Practice sites will not be asked to build new measures into EHRs if they do not have value outside of SIM. The one exception is the developmental screening, which is a key SIM behavioral health measure for pediatric practice sites. The SIM office contracted with Mathematica to develop guidance and deliver technical assistance related to developmental screening, aligning with the OHSU measure under development. In addition to aligning measures with other initiatives, the SIM office set out to ease the reporting burden for practice sites in SIM and CPC+. The SIM office will accept the CQMs that practice sites already report for CPC+.

The SIM office prepared reporting schedules for practice sites (including the CMHCs) that specify reporting requirements for pediatric and adult practice sites, as well as SIM cohort practice sites that participate in CPC+. The SIM office also created the CQM guidebook (see ***Appendix G1***) to reflect the simplified set of measures and provide detailed guidance to practice sites and CHITAs and will continue to use these resources in AY4.

Adult clinical quality measure set

Measure Condition	SIM Metric Title	Citation	CPC	QPP	TCPI	HCPF APM

Primary CQMs						
Depression	Preventive Care and Screening: Screening for Clinical Depression and	NQF 0418 CMS 2v6	✓	✓	✓	✓
Depression *(for CPC+ practices only, former CPC+ measure)*	Depression Remission at 12 months	NQF 0418 CMS 2v6		✓		✓
Diabetes: Hemoglobin A1c	Diabetes: Hemoglobin A1c Poor Control	NQF 0059 CMS 122v5	✓	✓	✓	✓
Hypertension	Controlling High Blood Pressure	NQF 0018 CMS 165v5	✓	✓	✓	✓
Obesity: Adult	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan	NQF 0421 CMS 69v5		✓	✓	✓
Substance Use Disorder: Alcohol and Other Drug Dependence	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	NQF 0004 CMS 137v5	✓	✓		✓
Substance Use Disorder: Tobacco	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	NQF 0028 CMS 138v5	✓	✓	✓	✓
Secondary CQMs						
Asthma	Medication Management for People with Asthma *(replaced to align with QPP)*	NQF 1799 CMS n/a		✓		✓
Fall Safety	Falls: Screening for Future Fall Risk	NQF 0101 CMS 139v5	✓	✓		
Maternal Depression	Maternal Depression Screening	NQF 1401 CMS 82v4		✓		✓
Substance Use Disorder: Alcohol	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	NQF 2152 CMS n/a		✓		✓
Breast Cancer	Breast Cancer Screening	NQF 2372 CMS 125v5	✓ *(clinical)*	✓ *(clinical)*	✓	✓
Colorectal Cancer	Colorectal Cancer Screening	NQF 0034 CMS 130v5	✓ *(clinical)*	✓*(clinical)*	✓	✓

Pediatric clinical quality measure set

Measure Condition	Metric Title	Citation	QPP	TCPI	HPCF APM

Primary CQMs					
Depression	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	NQF 0418 CMS 2v6	✓	✓	✓
Development Screening	Developmental Screening in the First Three Years of Life *(developed by Mathematica)*	NQF 1448 CMS – under development	No developmental screening measure		
Maternal Depression	Maternal Depression Screening	NQF 1401 CMS 82v4	✓		✓
Obesity: Adolescent	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	NQF 0024 CMS 155v5	✓	✓	✓
Secondary CQMs					
Asthma	Medication Management for People with Asthma *(replaced to align with QPP)*	NQF 1799 CMS n/a	✓		✓

Measure alignment work among the payers

Organizational members of the Colorado Multi-Payer Collaborative (MPC) have had multiple discussions since 2014 about the possibility of aligning quality measures in key domain areas. The concept of a "measure library" was advanced as a way to view measure alignment with "volumes" of measures identified in core clinical domains that each payer would agree to use. The possibility of a measure library has been of interest to members of the MPC because it would lessen the burden on practice reporting and set a consistent standard statewide for reporting progress in the quality and value of patient care.

As part of the SIM initiative in Colorado, the MPC has taken a number of steps to advance the alignment of quality metrics. A brief review of work to date, along with a summary of the activities over the last year, and those forecasted for AY4 includes:

1. Each organizational member of the MPC signed a Memorandum of Understanding in which they agreed to work toward measure alignment, as noted in earlier sections.
2. MPC members agreed on a set of shared milestones to measure practice progress with integrating behavioral and physical health. These milestones are based on shared metrics that payers collectively use to measure progress.
3. Health plans plan participated in an assessment (qualitative and quantitative) of opportunities to further quality measure alignment. This process helped identify the potential to align quality and performance measures among public and private payers in Colorado. Key findings are outlined below:

   Payers' use of measures:
   - All payers collect measures from practices;
   - Payers are encouraged to collect measures;
   - Payers use measures to inform quality and payment; and
   - Most payers use measures in contracting.

   Potential for aligning measures in Colorado
   - There is interest in aligning measures across plans
   - Barriers to measure alignment include:
     - It is difficult for large, national payers to participate in a single market when an initiative is not part of their larger organizational strategy.
     - Payers are concerned about how shared measures would be used—particularly out of context in a competitive environment.
     - Aligning measures would take significant effort within and across payer organizations and at a regional and national level. Some payers are unable to commit to the level of effort needed without a long lead time within their organization.
     - Similarly, aligning measures would require a substantial investment of resources by payer organizations ranging from retooling systems and infrastructure to contracting and support of practices, along with internal training and adjustment.

4. As a result, plans conceptually agreed to 1) work to align adult primary care measures across plans, and 2) explore the possibility of aligning a subset of hospital quality measures. In AY4, the MPC will form a quality measures workgroup to work on measure alignment. Plans intend to build on the work of the CMS/AHIP adult core measures set for adult primary care measures. Plans intend to build on the work of Colorado's statutory Hospital Transformation Program (HTP) for potential hospital quality measure alignment.

c. Plan for improving population health

State health needs assessment and priority setting

Leveraging population health assessments

The state of Colorado is large and geographically diverse, as outlined in the previous operation plan. As of 2017, there are an estimated 5.61 million people living in Colorado's 64 counties and two tribal nations. Approximately 85% of the population is concentrated on 20% of the state's land, primarily in the 200-mile stretch along the eastern side of the Rocky Mountains known as the Front Range. The remaining 15% of the population spans the state's 24 rural and 23 frontier communities. [4]

Colorado remains one of the fastest growing states in the nation with an 11.5% population increase from 2010 to 2017.[5] As of 2016, 68.6% of Colorado's population is non-Hispanic white, 21.3% is Hispanic, 4.5% is Black, 3.5% is RHIC Asian or Pacific Islander and 1.6% is Native American or Alaska Native, with 3.0% of the population identifying as two or more races. Seventeen percent of Coloradans aged five years or older speak a language other than English at home.[6] Colorado's diverse geographic and cultural landscapes lead to broad health needs and related issues among its residents, which can be compounded by barriers to accessing care due to geographic barriers (e.g. mountain passes) or low population density.

From the outset, SIM aimed to address these unique health care challenges and improve population health through two primary vehicles – an improved public health system and a transformed health care delivery system that integrates physical and behavioral health services – to create an effective and sustainable community-based system. Based on the social determinants of health model, the SIM plan for improving population health leverages the work of public health to reinforce improvements in the clinical health delivery system. The two systems seek to build a collaborative and outcomes-oriented model of health care and public health integration that helps reach the SIM goal, which is to improve the health of Coloradans by increasing access to integrated physical and behavioral health care services in coordinated community systems, with value- based payment structures, for 80% of Colorado residents by 2019. SIM defines population health as the health of a population, including the distribution of health outcomes and disparities in the population.[7] The SIM plan to improve population health continues to build on statewide efforts, including numerous local, state and national health assessments and plans outlined in the previous operational plan.

Resources to determine areas of high burden and cost

As shown in the previous operational plan in the 2011-2015 period, 27 LPHAs prioritized mental health and 22 prioritized substance use issues as a pressing public health need in their communities. Per 2016 data from the Office of Suicide Prevention, Colorado has the ninth highest suicide rate in the nation at 20.3 suicides per 100,000, and suicide is the second leading cause of death for Coloradans ages 10-34 years old. In 2016, there were 1,156 suicide deaths in Colorado, the highest recorded number (previously 1,093 in 2015). It exceeds other causes of death including diabetes (937), motor vehicle crashes (627), breast cancer (618), and homicide (230).[8]

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[4] Colorado Rural Health Center, "Colorado: County Designations, 2017," The State Office of Rural Health, http://coruralhealth.wpengine.netdna-cdn.com/wp-content/uploads/2017/07/2017-Rural-County-Designation.pdf

[5] U. S. Census Bureau. QuickFacts: Colorado. "Population, % change - April 1, 2010 (estimates base) to July 1, 2017, (V2017)." https://www.census.gov/quickfacts/table/PST045216/08.

[6] Ibid.

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

[8] Office of Suicide Prevention, Colorado Department of Public Health and Environment, "Annual Report: Suicide Prevention in

As of 2016, 19% of Colorado adults classified for risk of binge-drinking, higher than the national average of 16.9%.[9] While 10.6% of Coloradans reported 14 or more days of poor mental health in the last 30 days,[10] many Colorado residents are unable to access the behavioral health services they need. Despite an increase in the number of mental health and substance use disorder (SUD) providers in Colorado in recent years, there is a workforce shortage of providers with specialized skills to serve those with complex behavioral health needs. The greatest deficit of providers is in rural and frontier areas of the state. In fact, 82% of practicing psychiatrists, 86% of child psychiatrists, and almost all psychiatrists specializing in SUD treatment are based out of the Denver and Colorado Springs metro areas.[11] Additionally, more than a third (22 of 64) of the counties in Colorado have zero licensed psychologists.[12]

Colorado's statewide priorities and initiatives relating to SIM goals have been established through assessments and plans described in the previous operational plan (see ***Appendix G2***). The goals include reducing substance use (including alcohol, prescription drugs, and smoking); preventing suicide; promoting mental health; expanding health care access and capacity; improving health system integration and quality; and overall promotion of prevention and wellness. Addressing these important and pressing behavioral health care needs continues to require a strategic approach of incorporating systematic, coordinated interventions at various levels. Using the three buckets of prevention framework[13] as outlined by John Auerbach at the Centers for Disease Control and Prevention, areas of preventive care include:

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

Traditional clinical approaches include increasing preventive care and screening activities in health care settings, such as clinics and hospitals. These approaches are often reimbursed by insurers but are underutilized and, therefore, have low impact. Public health plays a role in supporting clinical interventions by providing data and technical assistance from public health agencies, which varies by intervention and site, and includes examples of screening tools and their proper use, resources for clinical workflow restructuring, referrals to community resources and others.

The second approach to prevention includes innovative approaches and evidence-based strategies to address community health needs. These approaches generally occur in clinical or health systems operating with value-based payment structures and include integrating clinical and community resources. Interventions at this level are typically not reimbursed in the traditional fee-for-service model. Examples include embedding health navigators as part of care teams to reduce patients' barriers to care and using health education to promote health literacy and patient self-management.[14]

Colorado 2016-2017," https://www.colorado.gov/pacific/sites/default/files/PW_ISVP_OSP-2016-2017-Legislative-Report.pdf. November 1, 2017.

[9] CDC and Prevention: Sortable Risk Factors and Health Indicators, https://sortablestats.cdc.gov/Index.html#/detail. Accessed March 19, 2018.

[10] Colorado Department of Public Health and Environment, VISION, "Area Profile: Colorado," https://public.tableau.com/shared/PXXT6Z6MX?:display_count=yes

[11] The Mental Health Funders Collaborative. The Status of Behavioral Health in Colorado: Advancing Colorado's Mental Health care. http://www.caap.us/pages/documents/2011StatusofHealth careColoradoReport.pdf. 2011.

[12] Colorado Health Institute, "Active, Licensed Psychologists: 2017," April 5, 2017. https://www.coloradohealthinstitute.org/data/%7B%22search%22:%22psychologist%22%7D

[13] Auerbach, John. The 3 Buckets of Prevention. J Public Health Management Practice, 2016, 22(3), 215–218.

[14] For additional information on the Colorado Department of Public Health and Environment's work to develop a competent

Community-wide approaches focus on factors that affect the health of a population and include system-wide interventions. These approaches seek to address factors, including social and environmental, that affect a person's health and well-being. Examples include supporting chronic disease self-management groups, promoting tobacco cessation and addressing the stigma of mental health.

CDPHE receives state and federal funding to handle tobacco cessation efforts in the state and has a full team dedicated to this work. The SIM Office continues to provide practices with community resources through its regional health connector program and clinical health information technology advisors, who help practices track clinical quality measures (CQMs), which include the tobacco cessation measure. In quarter 4 of 2017, 177 primary care practice sites and four (4) community mental health centers (CMHCs) reported that an average of 99.9% and 71.5% (respectively) of their patients were screened for tobacco use and received a tobacco cessation intervention if the screen was positive.

SIM continues to address the state's health needs by acting on these approaches to prevention and organized the plan for improving population health based on this framework. Most of the activities operate at more than one level.

Existing capacity and efforts aimed at population health

SIM population health strategies and activities

SIM designed its population health plan to align with other population health efforts in the state. This section outlines interventions that are underway or planned to support the integration of behavioral and physical health. SIM can build off the state's momentum and buy-in to achieve SIM goals and the governor's goal to become the healthiest state in the nation.

Traditional clinical approaches

Provider Education

The Colorado Department of Public Health and Environment (CDPHE) was charged with developing and disseminating three courses 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 to increase provider knowledge and skills in these areas.

In fall 2016, after working with the University of Colorado Department of Family Medicine (UCDFM), CDPHE's Children and Families Behavioral Health Integration Specialist, a position that is funded by SIM, distributed a Perinatal Mood and Anxiety Disorder Training to Maternal and Child Health (MCH) and SIM contacts. As of January 2017, 125 providers had viewed and completed the perinatal mood disorders training. In addition, this SIM-funded position at CDPHE developed an online Pregnancy-Related Depression Resource Hub in coordination with the Maternal Wellness Specialist at CDPHE. This resource includes training opportunities, toolkits for screening, billing and making referrals, and much more. It has been disseminated to SIM practices and is maintained through CDPHE. Another provider education opportunity coordinated by SIM staff was a live webcast of the 2020Mom Forum on Maternal Mental Health and Infant Mental Health drawing more than 60 participants, including SIM providers and practice transformation coaches. The 2020Mom event also included a panel of maternal mental health experts working in Colorado on innovative practices that integrate efforts to promote maternal and early childhood mental health in behavioral health and pediatric settings, as well as through a public health lens.

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health navigator workforce in Colorado, please visit: https://www.colorado.gov/pacific/cdphe/health-navigator.

In AY4, SIM Staff will continue to find and promote maternal mental health learning opportunities for the SIM community. One example includes a two-day in-person training from Postpartum Support International, scheduled for August 2018, which is hosted by CDPHE's MCH department, with staff support from the SIM team.

The Children and Families Behavioral Health Integration Specialist also worked in coordination with UCDFM to develop a provider education course on Adverse Childhood Experiences (ACEs), which was disseminated to SIM and MCH contacts. It is hosted on the UCDFM provider education platform and continues to be accessed by SIM providers and practice transformation coaches.

There have been numerous delays and obstacles with executing the contract with the entity chosen to develop the depression in men, obesity and depression courses. Despite the previous delays, CDPHE has a contract with UCDFM to develop provider education materials for these two topics, with anticipated completion by July 2018. All three courses were each expected to reach a minimum of 100 providers, who practice in the fields of primary care, family practice, behavioral health, pediatrics, public health and dietetics.

CDPHE developed a provider education and evaluation plan in late 2015 that includes descriptions of providers, who will receive education, the type of education to be provided including topics covered, a description of the communication strategies to disseminate the trainings and an education evaluation plan. The provider education plan was updated in the summer of 2017 to reflect progress made.

CDPHE continues to work with other SIM-funded entities, including the Office of Behavioral Health (OBH) and the University of Colorado, School of Medicine, to align and leverage the educational opportunities available for providers and other relevant staff to support the integration of behavioral health into primary care settings. These partnerships, which provide relevant, evidence-based, and up-to-date education, will continue beyond the life of the SIM initiative. Please see the workforce capacity section of the plan for information on how CDPHE will coordinate with OBH to advance training opportunities.

Population Health Measures

Population health monitoring provides the structure for monitoring and surveillance to inform the SIM evaluation. CDPHE developed SIM's behavioral health population health measure set, which is detailed in the previous operational plan. Measures were based on existing Colorado population health measures and intended to fill gaps in existing data. Selected measures align with the SIM clinical quality measures (CQMs), define the population's burden of a health condition, and are timely and sustainable. Ideally, they will be available at the state and county levels. CDPHE focused on traditional physical and behavioral health measures, which are not as robustly monitored in the public health system. Depression-specific questions were added to the 2016 Behavioral Risk Factor Surveillance System to enable increased behavioral health tracking in Colorado, and the SIM team worked with the Colorado Health Institute (CHI) to add questions about mental health and substance use to the Colorado Health Access Survey. Please see the CHI website for Colorado Health Access Survey (CHAS) (To see report, ***Appendix H1***) data and reports, including a brief about access to mental health and substance use: www.coloradohealthinstitute.org/research/unmet-challenge.

There are 18 behavioral and 16 physical health measures providing corollary population-level data to the SIM-required CQMs. The population health measures are informed by 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.

Efforts Focused on Children and Families

The SIM-funded Children and Families Behavioral Health Integration Specialist at CDPHE convened a SIM Pediatric

Stakeholder Group in July 2017, to leverage the SIM effort to support the pediatric population of Colorado and identify a project that could help sustain SIM successes in this area. The group is composed of and has retained high levels of participation from robust and diverse pediatric stakeholders involved in SIM including pediatric and family practice providers, behavioral health professionals, public health professionals, funders and SIM staff. The group spent the last half of 2017 identifying gaps or barriers to achieving fully integrated care in the pediatric setting, and in early 2018, selected the problem to address based on urgency and perceived importance by experts in the room.

The problem the group prioritized is as follows: Currently, most value-based payment models are based on shared savings in a population with relatively high prevalence of chronic disease, with a goal of reducing utilization of services through improved coordination of care. The value proposition in child health is different; the goal is to maximize the wellness of a population by reducing the prevalence of chronic disease and reducing the costs of care during the lifespan of the population. The difference in the epidemiology of the two populations require a different kind of alternative payment model (APM) that focuses on investment in child health promotion (physical, mental and social) more than chronic disease management. Currently, there are few such payment models in existence. To address the problem, the group proposed a strategy that would include developing a business case for pediatric services along a full continuum of care including health prevention and promotion, which are key components of integrated care in the pediatric setting. SIM helped share information with this group but will not continue to participate.

Sustainability has been a cornerstone of conversation for this stakeholder group, and was a primary criterion used in deciding the priority for this group, in addition to impact (i.e. extent to which this will benefit children and families) and feasibility (i.e. time, money, staff capacity and expertise, political, agency, and provider will).

Innovative patient-centered care and funding models and/or community clinical linkages

Regional health connectors (RHCs)

The Patient Protection and Affordable Care Act authorized The Agency for Health Care Research and Quality (AHRQ) to create a national Primary Care Extension Program (PCEP). The program deploys community-based health extension agents to help providers "improve the accessibility, quality, and efficiency of primary care systems" and "collaborate with local health departments … and other community agencies to identify community health priorities and … address the social and primary determinants of health."[15] SIM saw this model as an opportunity to create synergy between its primary vehicles for improving population health – an improved public health system and a transformed health care delivery system with integrated physical and behavioral health services. The previous operational plan includes a detailed history of the grant and model for the health extension agents.

Since the submission of that plan, Colorado has launched a new workforce of 21 RHCs across the state. Inspired by the PCEP model, an RHC is a local resident whose full-time job is to improve the coordination of services to advance health and address the social determinants of health. RHCs promote connections among clinical care, community organizations, public health, human services, and other partners. They implement activities to improve clinical-community linkages, remove barriers to health care and address factors that influence health. RHCs, who work with practice transformation efforts funded by SIM, support providers and their patients by:

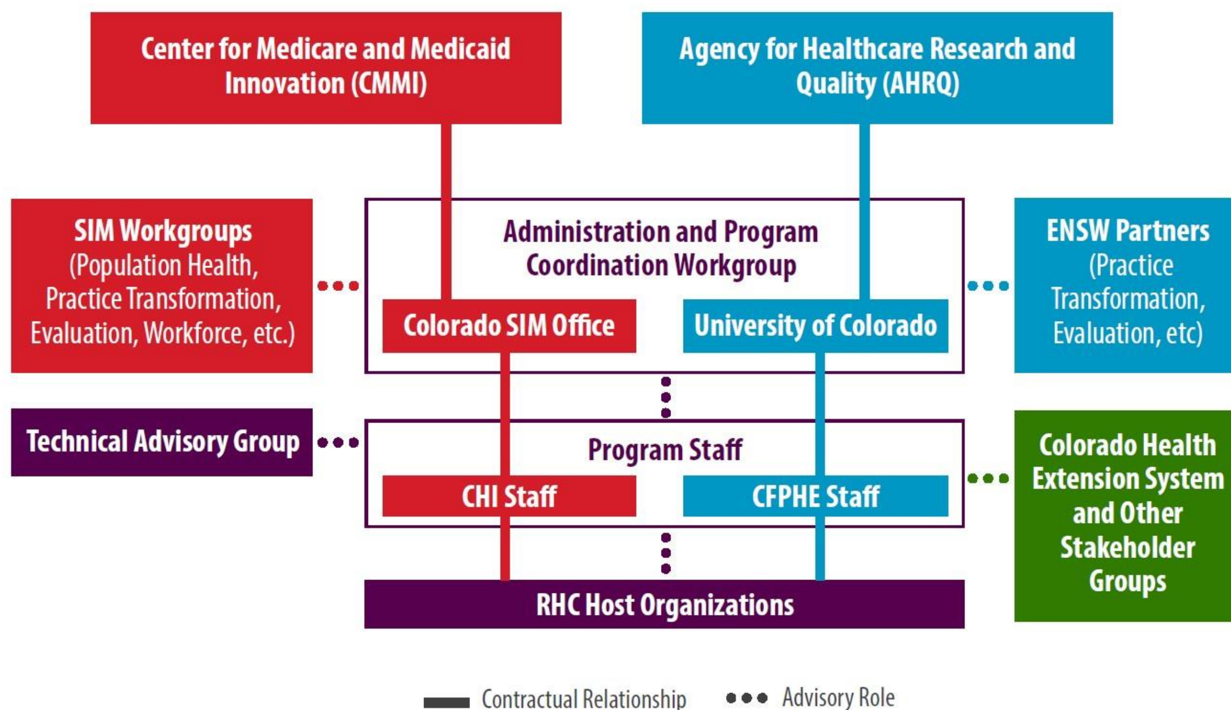
- Connecting practices with resources to improve health, such as community tobacco cessation groups, chronic disease management programs, school-based health services, and mental health response trainings;
- Connecting practices to appropriate practice transformation programs, such as SIM, EvidenceNOW Southwest (ENSW), the Transforming Clinical Practice Initiative (TCPi), and Regional Care Collaborative Organizations (RCCOs).

The RHC program is supported by two federally funded initiatives: SIM and ENSW, which is one of seven regional cooperatives funded by AHRQ to provide small primary care practices with support to improve heart health in their patients using the latest medical evidence.

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

As shown in Figure 1, the RHC program was developed and is managed by CHI and the Trailhead Institute (previously the Colorado Foundation for Public Health and the Environment) under contract with the SIM office (for SIM funding) and the University of Colorado Department of Family Medicine (for ENSW funding). CHI is responsible for delivering on SIM contractual components related to RHC services. 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 Colorado Regional Health Information Organization (CORHIO) and the state’s health insurance exchange, as well as its experience conducting research in local areas across the state related to behavioral health integration. For more information, please see the RHC Program Structure, Administration, and Funding handout in ***Appendix H2***.

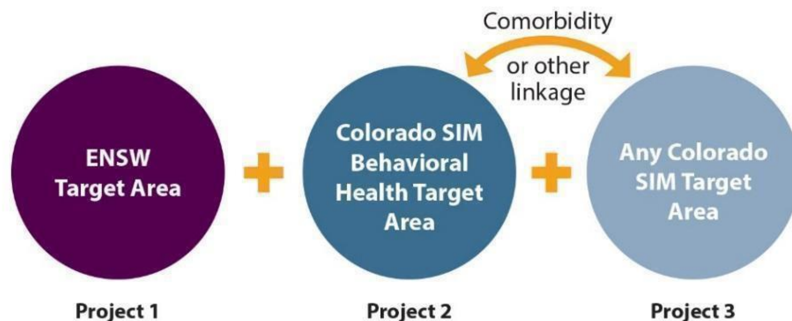
Figure 1. Colorado Regional Health Connector program coordination and oversight relationships



CMMI and AHRQ approved a braided funding strategy proposed by the SIM office, RHC program staff and others. SIM provides 70% of the funding for each RHC and ENSW provides the remaining 30% of the funding with specific contractual requirements to ensure that funding is not comingled. The approved funding allocation functions similarly to a pay-for-value payment model for providers. Rather than paying for a specific number of meetings with specific stakeholders, RHCs are paid to develop and implement three community-specific projects through milestone-based contracts.

RHC community-specific projects are directly linked to SIM and ENSW statewide target areas shown in the tables

below. RHCs chose appropriate target areas from these lists, which are based on unique community needs, and developed a locally-relevant project to address those needs. Each RHC developed one project related to ENSW target areas and two projects related to SIM target areas:



1. Each RHC chose a community-specific project that is directly linked to one of the ENSW target areas around heart health. The ENSW target areas and a few example projects are shown in Table 1 below. A variety of projects were chosen to satisfy this requirement, depending on the specific needs of the community. For more information on the projects chosen in every region, please see the RHC Project List in ***Appendix H3***.
2.

Table 1. ENSW Target Areas and Example RHC Projects

ENSW Target Area	Example RHC Projects
Cardiovascular Disease	● Provide tools and processes for quick, effective referrals to local tobacco cessation services to prevent and reduce the use of tobacco, vaping, and marijuana among youth (Region 2) ● Create food prescriptions for clinics to provide low-income individuals/families with increased access to healthy food and promote food security (Region 10)
Cholesterol	
Hypertension	
Obesity	
Substance Use – Tobacco	

1. Each RHC chose a community-specific project that is directly linked to one of the SIM target areas around behavioral health. The SIM behavioral health target areas and a few example projects are shown in Table 2. A variety of projects were chosen to satisfy this requirement, depending on the specific needs of the community. For more information on the projects chosen in every region, please see the RHC Project List in ***Appendix H3***.

Table 2. SIM Behavioral Health Target Areas and Example RHC Projects

SIM Behavioral Health Target Area	Example RHC Projects
Anxiety*	● Involve providers and young people in the development of an action plan to reduce youth alcohol and drug use (Region 1) ● Expand access and knowledge of mental health resources by engaging the community in Mental Health First Aid trainings (Region 7, Region 17)
Child Development Screenings	
Depression	

Substance Use – Alcohol	● Identify and engage practices in providing more mental health services, including telemental health (Region 18)
Substance Use – Prescription Drugs	

2. Each RHC chose a community-specific project that is directly linked to any of the SIM target areas and supports the project linked to behavioral health in Project 2. The goal of this project is to address comorbidities or other linkages between the SIM target area chosen in Project 2 and another SIM target area. SIM target areas and a few example projects are shown in Table 3. A variety of projects were chosen to satisfy this requirement. For more information on the projects chosen in every region, please see the RHC Project List in ***Appendix H3***.

Table 3. All SIM Target Areas and Example RHC Projects

SIM Target Area	Example RHC Projects
Anxiety*	● Build a free medical clinic in a food pantry with co-located enrollment specialists to improve access to health care and social services (Region 3) ● Provide information and resources about mental health services at local community venues such as farmer's markets and community gardens (Region 11) ● Improve access to care by developing policies for reliable transportation to medical appointments and by providing health and social services at local "pop-up" events (Region 14)
Child Development Screenings	
Depression	
Substance Use – Alcohol	
Substance Use – Prescription Drugs	
Asthma	
Diabetes	
Hypertension	
Obesity	
Prevention – Breast and Colon Cancer	
Prevention – Flu*	
Safety – Falls	
Substance Use – Tobacco	

*These are no longer SIM clinical target areas but are still aligned with SIM population health target areas

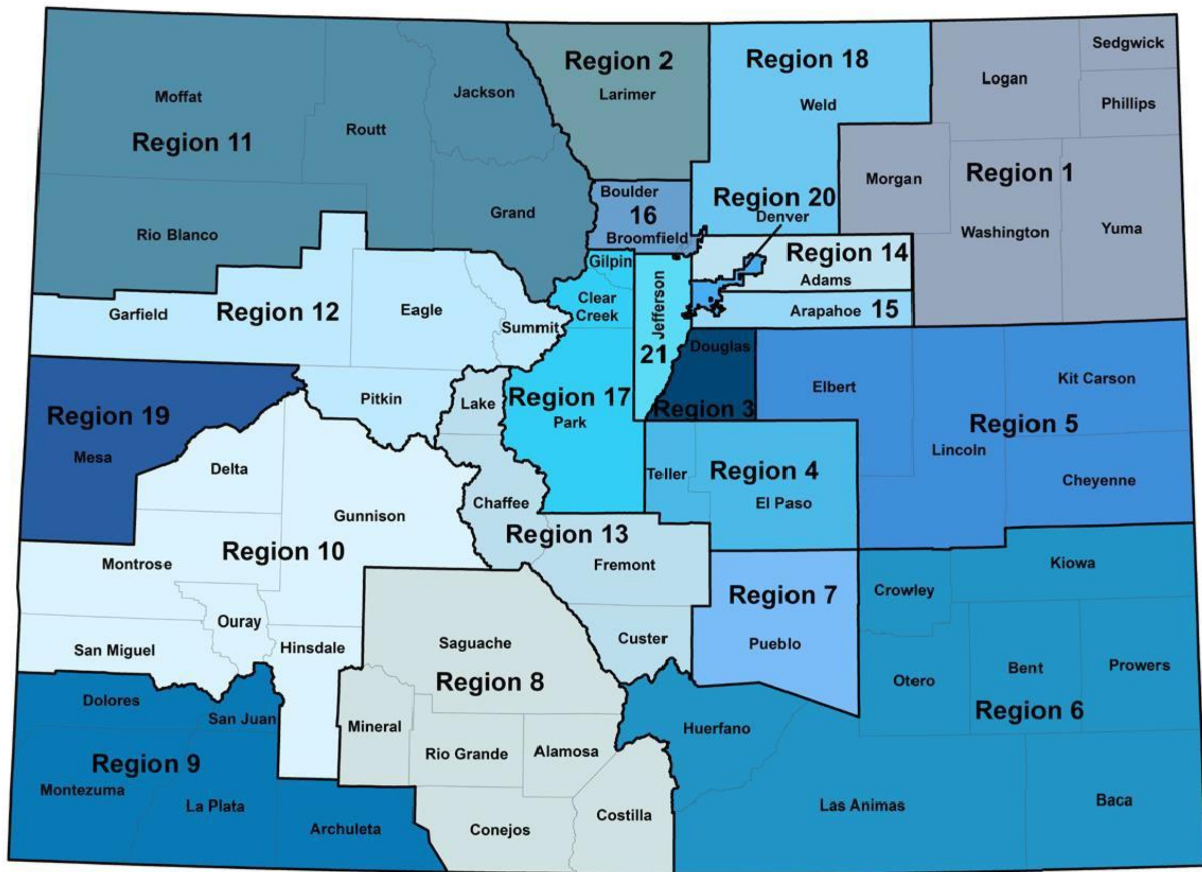
An interactive map lists three community-specific projects in each region: http://regionalhealthconnectors.org.

In addition to the three community-specific projects described above, the RHC Statement of Work outlines specific responsibilities to be completed on an as-needed basis to support each initiative. For example, an RHC might be asked to engage practices in their region for the SIM initiative or to participate in an ENSW evaluation site visit. These as-needed, initiative-specific responsibilities are expected to constitute a small portion of the total RHC workload, and the braided funding structure enables the RHC to fully support both initiatives.

To ensure work is locally driven, each RHC is hosted by an organization or collaboration with existing relationships and a history of community-based work in the region. The host organization or collaboration (host) receives funding to hire and manage an RHC for the region. The host enables the RHC to coordinate stakeholders and mobilize action to address local priorities by:

- Ensuring the RHC is engaged in existing relationships and forging new relationships with local partners;
- Supporting the RHC as he/she develops and implements three specific regional projects;
- Expanding the scope of a host's work and joining a statewide network to develop the RHC workforce; and
- Enabling the RHC to serve communities across the region and address local priorities rather than focusing on organization-specific projects.

Through a competitive procurement process, CHI and the Trailhead Institute selected local organizations across



the state to host an RHC in their regions. The RHC regions largely map to the 21 Health Statistics Regions (HSRs) in Colorado. Adjustments to move Grand County from Region 12 to 11 and Teller County from Region 17 to 4 were proposed by potential hosts and approved during a procurement process. The final RHC regions and selected hosts for each region are shown in the map and table:

Regio n	Host Organization or Collaboration	Counties
1	Centennial Area Health Education Center	Logan, Morgan, Phillips, Sedgwick, Washington, Yuma
2	Health District of Northern Larimer County	Larimer
3	Tri-County Health Department	Douglas
4	Community Health Partnership	El Paso, Teller
5	Centennial Area Health Education Center	Elbert, Lincoln, Kit Carson, Cheyenne
6	Otero County Health Department	Baca, Bent, Crowley, Huerfano, Kiowa, Las Animas, Otero, Prowers
7	Pueblo City-County Health Department	Pueblo
8	San Luis Valley Behavioral Health Group	Alamosa, Conejos, Costilla, Mineral, Rio Grande, Saguache
9	Southwest Colorado Area Health Education Center	Archuleta, Dolores, La Plata, Montezuma, San Juan
10	Tri-County Health Network	Delta, Gunnison, Hinsdale, Montrose, Ouray, San Miguel
11	Northwest Colorado Community Health Partnership	Grand, Jackson, Moffat, Rio Blanco, Routt
12	West Mountain Regional Health Alliance	Eagle, Garfield, Pitkin, Summit
13	Chaffee County Health Coalition	Chaffee, Custer, Fremont, Lake
14	Tri-County Health Department	Adams
15	Tri-County Health Department	Arapahoe
16	City and County of Broomfield Health and Human Services	Boulder, Broomfield
17	Central Colorado Area Health Education Center	Clear Creek, Gilpin, Park
18	North Colorado Health Alliance	Weld
19	Mesa County Health Department	Mesa
20	Mile High Health Alliance	Denver
21	Jefferson County Public Health	Jefferson

By May 2017, all 21 RHC Host Organizations had completed the hiring process for the RHC position in their regions. As we approach the one-year anniversary of hiring an RHC in every region, it is clear that RHCs are having an influence across Colorado. Please read a few of the early success stories below and listen to RHC podcasts on the SIM website (https://www.colorado.gov/healthinnovation/news-7):

In Region 9 (Dolores, Montezuma, San Juan, La Plata, and Archuleta Counties), RHC Mary Dengler-Frey helped organize a free Suicide Prevention Community Summit in November 2017. The event featured Brief Suicide Intervention Training (BSIT) and community focus groups. A few weeks later, one attendee reached out to Mary about a friend who was contemplating suicide. The friend was admitted to a local hospital and the attendee followed up with Mary to say that if she hadn’t attended the summit, she might not have recognized the warning signs that her friend needed help.

In Region 17 (Gilpin, Clear Creek, and Park Counties), RHC Ashley Hill is working to improve access to care. All three counties lacked permanent health clinics when Ashley began her work as an RHC. A temporary clinic serving Clear Creek and Gilpin Counties opened in July 2017. Ashley is working to find funding and other support to help construct a permanent clinic in Idaho Springs. In November, Park County voted to create a health service district that could financially support a health system occupying an empty clinic building located in Fairplay, CO. Ashley helped organize community members before the vote and is the Vice Chair of the South Park Health Service District.

In the metro Denver area, RHC Laura Don connected a primary care practice with a behavioral health provider in the same office building! As one of the first successes of the RHC program in Summer 2017, this example demonstrates the power of dedicated support for coordination. Although both partners were interested, no one had the time to make the connection before Laura's visit.

In AY4, RHCs will build on lessons learned that will inform future implementation and sustainability planning efforts. Two items that will have significant impact on the work in AY4 are outlined here:

- **Program-specific evaluation is critical to sustainability.** The SIM and ENSW evaluations conducted by TriWest and UCDFM, respectively, were originally intended to cover the RHC program. No additional funding was allocated to a specific evaluation of this program. During AY2, the unique nature of this component of both initiatives drew attention from both statewide and national stakeholders and it became apparent that an in-depth evaluation of the RHC program would be needed to support a sustainability plan. Monthly and quarterly reports submitted by the RHCs have been modified in AY3 to collect cleaner and more targeted evaluation data. RHCs also submit information about their experience and skills in a biannual core competencies checklist. Additional funding was allocated in AY3 to support a program-specific Social Network Analysis (SNA) to collect bi-directional partnership information from regional stakeholders. Through these various efforts, the program has collected a rich set of data about RHCs and the partnerships they create or support in each region; however, the program has struggled to identify the analytic capacity to transform this data into meaningful reports and takeaway points. While the program continues to collaborate with TriWest and UCDFM to analyze this information and support initiative-wide evaluation efforts, there is a distinct need for "in-program" analytic capacity. The AY4 funding request includes dedicated staff support to conduct analysis, coordinate with independent evaluators and create program-specific summaries and reports.

- Additional RHC positions are likely needed to effectively serve the entire state. As described above, there are 21 RHC regions across the state that are based primarily on the CDPHE Health Statistics Regions. Each region is served by one full-time RHC. While RHCs have connected with stakeholders across the state, some RHC host organizations and RHCs have noted that their regions cannot be effectively served by a single person.

- For example, the mountainous Region 11 spans five counties in northwest Colorado (Moffat, Rio Blanco, Routt, Jackson, and Grand counties). RHC Stephanie Monahan works out of Steamboat Springs, which is centrally located in Routt county. Some days, Stephanie drives 90 miles west to reach Meeker, CO, the most populous town in Moffatt County. On other days, she drives 80 miles east to reach Granby, CO, the most populous town

in Grand County. From her central location, the trip in either direction takes about 3 hours roundtrip, in good weather. She serves as a conduit for information between her partners across the region, but she knows that a single collaborative partnership between these partners is impractical. In addition, the community in Grand County has already established a strong health alliance, which has been working to improve health in the county for decades. Rather than duplicate those efforts, Stephanie strives to support the work and leverage the momentum to address regional priorities. The partnership has been fruitful, but Stephanie envisions a future RHC structure that provides more staff support in this region so that an RHC host organization can continue to provide regional services and dive deeper to support local efforts in Granby, Meeker, and across the region.

- The RHC program will collect information from Region 11, as well as other regions across the state that have identified opportunities to improve the model. The requests and suggestions for improvement will be incorporated into a program sustainability plan developed in AY4.

As described above, the RHC Program is a collaboration between several initiatives and organizations: SIM, ENSW, the Colorado SIM Office, UCDFM, CHI, Trailhead Institute and 21 RHC host organizations across the state (not to mention myriad stakeholders working with each RHC). No single organization has authority over the entire program; therefore, a sustainability group that represents the initial funders, RHCs, host organizations, and other stakeholders will be convened to make decisions about the future of this collaboration. SIM team members and CMMI representatives will join the RHC team for a sustainability discussion during the CMMI site visit in May.

The RHC Sustainability Group shall consist of nine members who represent key stakeholders engaged in the Colorado RHC Program:

- Five members will represent the RHCs and RHC Host Organizations, with a mix of organizational types and geographies that reflect the diversity of these stakeholders.
- Two members will represent the original two funders, with one delegate from ENSW and one delegate from SIM.
- Two members will represent the clinical partners engaged in this program, with a mix of front-line health care provider and health systems administrator experience.

RHC program staff will drive the decision-making process and implement the decisions of the RHC sustainability group but will not be considered members of the group.

The RHC Sustainability Group is expected to address each of the following high-level questions by fall 2018:

- What support functions are needed to sustain the Colorado RHC Program after July 2019?
- What is the appropriate governance structure for the Colorado RHC Program after July 2019?
- What improvements should be made to the Colorado RHC Program design after July 2019?
- Which organization will fund the Colorado RHC Program after July 2019?

In AY4, the SIM office will continue to support implementation of the RHC program by joining the RHC Sustainability Group and overseeing the final year of funding for the program. The SIM office will continue to work with the population health workgroup to provide guidance on implementation and sustainability.

Behavioral health transformation collaboratives (BHTCs)

In addition to the population health-facing work of the RHCs, SIM seeks to influence population health efforts through a joint effort between CDPHE and The Denver Foundation. In September 2015, the two entities released a joint request for application (RFA) for a public-private partnership designed to eliminate overlap and redundancies and leverage funding opportunities focused on behavioral health and wellness in Colorado. While the original intent was to have multiple cohorts of BHTCs similar to practice cohorts, the SIM office and CDPHE

decided to go with one group of awardees. This funding supports existing collaboratives that are formally working together to meet shared behavioral health goals. The collaboratives comprise community organizations and government agencies (including LPHAs) that have 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 communities, the collaboratives seek 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 is supporting 40 projects related to increasing access to behavioral health treatment and CDPHE (with SIM funding) supports two collaboratives focused on behavioral health prevention and screening. The goals of the treatment-focused funding are:

1. Reduce and remove barriers for Coloradans with high behavioral health care needs in accessing behavioral health care;
2. Build on innovations and investments 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.

Population health work - BHTCs

Aurora Mental Health Center (AuMHC), in the metro Denver area, and the Health District of Northern Larimer County (HDNLC), in northern Colorado, are the two BHTCs funded jointly by SIM and the Denver Foundation to focus on prevention in a collaborative. Both entities are successfully working with their local school districts to coordinate the systems to improve behavioral health screening and referral. Since execution of the second-year contract in August 2017, AuMHC screened 2,269 youth through its coordination with Aurora Public Schools. From these screenings, AuMHC referred 96 students to community resources and behavioral health services. A large focus of the work of HDNLC has been able to coordinate referrals to behavioral health resources coming from Poudre School District schools, community primary care providers and the community at-large. In the August 2017-2018 contract year, HDNLC has had 114 children/youth/young adults referred from schools, 234 referred from primary care providers, and 532 referred from the community and served 632 children/adolescents/young adults with screenings, needs assessments and support, care coordination services, and more. These are SIM-funded activities and the belief is that the baseline for each is zero. The SIM team started to look at these BHTC metrics to gain a better understating of SIM's influence on the population health pillar.

In addition to the qualitative successes of increased numbers of youth now connected to services by AuMHC and the HDNLC, the work of both BHTCs are positively impacting the community on personal levels. In Aurora, both teachers and students have expressed their appreciation and satisfaction with the ongoing work. As noted in a recent progress report, one teacher noted that one of AuMHC's facilitators "really excels with building relationships and making the content connect with students," while students have expressed how they have

enjoyed the dynamic conversations that occur in the prevention education sessions and wish to keep in contact with the facilitators in the future.

Further, survey data gathered upon completion of these prevention education sessions shows that students are increasing their knowledge around alcohol and substance use. In Larimer County, the Child, Adolescent and Young Adult Connections (CAYAC) team has had tremendous success with connecting community members to behavioral health resources. There was a very clear level of unmet need from the community, and with the establishment of this team, both providers and community members now have an additional avenue for assistance. One provider stated that "Before CAYAC, we'd sometimes have kiddos in crisis in our exam rooms and we'd be challenged to find them the crisis intervention help they needed right away. Now when this happens during the day we can reach out and recruit help from CAYAC providers right away and hand them off to a place where they can get immediate help to deal with the crisis." For community members, 92% responded that they believed CAYAC helped to reduce or eliminate barriers they'd faced in the past, with one responding: "We really appreciate CAYAC's services. [We] feel like we have a better handle on the services and needs for our particular situation and feel like we have some great partners to reach out to if we come to an impasse in the future."

Both BHTCs have built great momentum from the beginning of the SIM initiative and will continue to expand and hone their services and level of coordination across their communities during AY4 while looking toward sustainability after funding concludes.

As both BHTCs are immersed in implementation of their activities, they are in the process of determining which areas of their work may be sustainable after SIM funding ends in July 2019. Demonstrating the need as well as indicators of success for this work in their partnerships with local school districts and communities has been integral to this work. In Aurora, work in Aurora Public Schools (APS) has been successful to the point that APS will adopt a curriculum for universal implementation of prevention education for the 2018-2019 school year. This adoption will occur in AY4, which allows APS to lead the charge for its students once SIM funding ends.

The services that the Health District of Northern Larimer County (HDNLC) provides to its community is serving such a high need that the county began exploring whether they could sustain this program by billing health plans for the work. Through an assessment, HDNLC determined that most of its services are not billable under the current program structure, and the level of documentation required to bill for these services would be a barrier for program administration staff and community members seeking the services. Despite these findings, the HDNLC continues to explore pathways to sustaining its work and are working to identify support resources and next steps to ensure continuation of the program when SIM funding concludes.

Community-wide approaches

Local public health agencies (LPHAs)

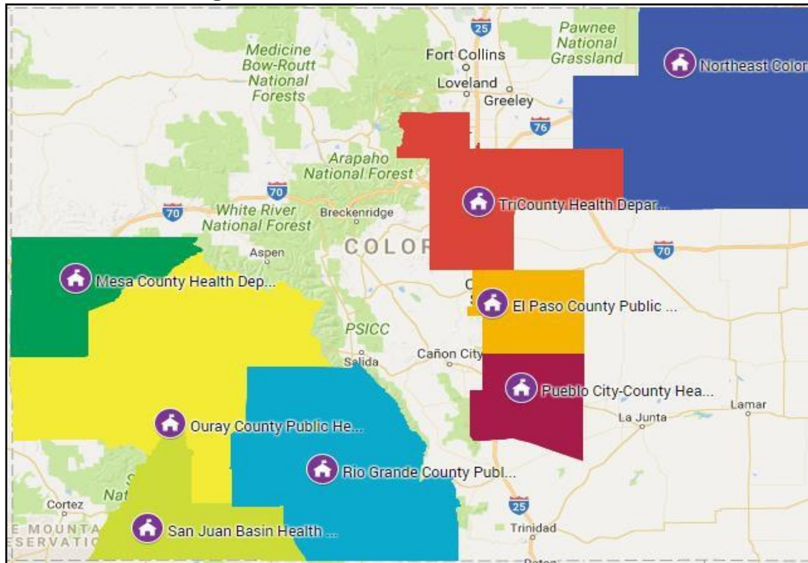
Based on an RFA released in October 2015, CDPHE selected eight LPHAs across the state to receive SIM funding to support activities that promote behavioral health and improve community-based awareness, prevention and screening of behavioral health disorders. This effort will improve the health of Coloradans by building capacity and support for the implementation of behavioral health promotion, prevention and effective treatment of behavioral health disorders. These activities will also complement corresponding SIM activities to increase access to integrated physical and behavioral health care services in coordinated systems of care. The two focus areas will continue to address in AY4 are:

1. Behavioral health promotion, outreach, education, and/or stigma reduction focused on evidence-based/research-informed behavioral health, wellness, and prevention strategies; and
2. Coordination of systems that improve integration of behavioral and physical health services.

LPHAs designed projects to influence behavioral health at a population health level based on community and regional needs. LPHAs regularly report on progress, successes and barriers in quarterly reports, monthly check-in calls, and correspondence (e.g. e-mail, phone calls as needed). CDPHE manages this work with SIM funding.

While eight LPHAs were selected to fund, the agencies' work involves 31 of Colorado's 64 counties as many of the host agencies work with regional collaboratives to ensure wide-ranging impact of their work. A map of host agency locations with surrounding counties is shown below.

SIM Colorado LPHA host agencies and counties involved



The following table includes details about host agencies that received SIM funding to conduct population health activities, counties involved and priority areas for population health activities.

SIM Colorado-funded LPHAs, with areas of focus, goals, and expected results

Grantee Name	County(ies) included	Health Issue(s) Addressed	Goals	Expected Results of Activity(s)
El Paso County Public Health	El Paso	Youth Depression	Reduce the incidence of depression among youth in El Paso County.	1. Decrease in youth suicide, youth suicide attempts. 2. Increase in youth depression screening, referral to treatment, coordination of care and follow-up. 3. Increase in trust and communication among partner agencies to better support youth at-risk for suicide. 4. Decrease in stigma among adults and youth to encourage help seeking behavior for youth
Mesa County Health Department	Mesa	Suicide	Increase community awareness of risk and protective factors related to suicide to decrease the stigma associated with seeking behavioral health services in Mesa County.	1. Increased community member awareness of suicide risk and protective factors. 2. Increased community awareness of resources to support people who are contemplating suicide. 3. Reduction in stigma associated with suicide and seeking behavioral health services. 4. Increased awareness of resources, gaps, and overlaps between behavioral health and primary care. 5. Increased capacity of primary care providers to engage clients in behavioral assessments. 6. Increased connection to services for individuals identified as high risk through the screening.
Northeast Colorado Health Department	Logan, Morgan, Phillips, Sedgwick, Washington, Yuma	Child Health Development	To promote behavioral health, well- being and prevention in a six-county region in northeast Colorado using evidence-based strategies and improving integration of behavioral health	1. Greater awareness in the region about pregnancy-related depression and depression in men. 2. Better integration between behavioral health and primary care providers in Logan, Morgan, Phillips, Sedgwick, Washington and Yuma counties.

Ouray County Public Health	Delta Gunnison Hinsdale Montrose Ouray San Miguel	Reduction of stigma associated with behavioral health	Improve behavioral health help-seeking attitudes and practices of the low socioeconomic (SES) status population of the West Central Public Health Partnership (WCPHP) region. Maximize access to behavioral health preventive services for low SES populations through assessment, partnerships, systems building and community-clinical linkages in the WCPHP region.	1. Decrease in behavioral health stigma among low SES populations in WCPHP region. 2. Increase in low SES populations screened, identified and referred for behavioral health issues. 3. Improved understanding of resources and gaps in behavioral health and primary care system and service integration.
Pueblo City-County Health Department	Pueblo	Integrated primary care	Improve access to integrated primary care and behavioral health care services in coordinated community systems for Pueblo County residents.	1. Improvement of Pueblo County's behavioral health status through outreach, engagement and community development designed to systematically integrate primary care and behavioral health services. 2. Improved awareness and understanding of the link between chronic disease and behavioral health. 3. Decreased stigma and increased utilization of behavioral health care among community members and health care providers in Pueblo city and county.
Rio Grande County Public Health Agency	Alamosa Conejos Costilla Mineral Rio Grande Saguache	Preventive Services	Increase access to preventive services in San Luis Valley by integrating behavioral health and primary care.	1. Increase in patients screened, identified, referred and documented for behavioral health concerns from baseline provided in the patients' health records. 2. Increase in community member and provider knowledge of behavioral health care services available in Rio Grande County. 3. Decrease in behavioral health care stigma among community members in San Luis Valley.
San Juan Basin Health Department	Archuleta La Plata San Juan	Vulnerable Individuals and Families	Improve the health of vulnerable individuals and families by increasing access to integrated primary care and behavioral health services in coordinated community systems.	1. Increased collaboration with San Juan Basin Health Department around behavioral health issues by collaborators, partners and stakeholders in Archuleta, La Plata, and San Juan counties. 2. Increased knowledge of behavioral health needs, gaps, target populations, and potential strategies. 3. Increased community-level awareness of behavioral health issues.

TriCounty Health Department	Denver Adams Arapahoe Douglas Boulder Broomfield Jefferson	Increase access to screening and integrated treatment for behavioral health issues for low-income people	Reduce stigma of behavioral health issues and increase openness to behavioral health care help-seeking attitudes and behaviors in low-income populations in the seven county Denver metro region. Increase access to behavioral health screening and treatment for low-income populations in the seven-county Denver metro region, through coordination of community systems that improve integration of behavioral health services and primary care.	1. One organization will pilot the stigma reduction messaging campaign. 2. The Common Messaging Campaign will be shared with at least eight community organizations the first year reaching approximately 150,000 residents in the Denver metro region. 3. Community assessments and gap analyses will be conducted in conducted in the seven counties of the Denver metro region. A plan to address gaps found in the community assessments to be implemented in years two and three of the grant in the seven counties of the Denver metro region. 4. All organization that participate in the screening access and referral assessment will be invited to participate in the plan to address gaps.

Population Health Work - LPHAs
In AY4, CDPHE will continue to work with SIM population health partners at CHI to remain informed about their work with RHCs and ensure as much alignment between RHCs and LPHAs as possible. Two RHCs work with their respective LPHAs (San Juan Basin Public Health and Rio Grande County Public Health) to expand the work of Tri-County Health Department's Let's Talk Colorado stigma reduction campaign. Let's Talk Colorado continues to expand its efforts around the state. In the metro area in the first quarter of the second contract year, Tri-County Health Department (TCHD) estimates more than 11 million impressions of the campaign via varied methods (including billboards, bus shelter posters, community newspapers, and Pandora streaming radio).

Northeast Colorado Health Department (NeCHD) has had recent success with engaging providers, which has been difficult for grantees across the state, about Pregnancy-Related Depression (PRD). They have developed and are distributing PRD toolkits to practices that include information about NeCHD, signs of PRD, local resources for women and families affected by PRD, common billing codes and reimbursement for PRD screening and treatment, and PRD awareness campaign materials. The toolkits have been well-received by those, who have received them. NeCHD has had great success in its work with Assuring Better Childhood Development (ABCD) to work with practices around screening for PRD.

One clinic NeCHD met with several times in conjunction with ABCD started with a baseline of 17% completion of the recommended screening with patients. By the second meeting with NeCHD and ABCD, the clinic jumped to 98% of screening patients at the recommended times and remained at that rate for the third/ final meeting.

LPHA grantees particularly have had success coordinating and involving community stakeholders in their SIM-funded population health efforts. El Paso County Public Health convenes a monthly Suicide Prevention Workgroup, which comprises more than 60 members from multidisciplinary community agencies. The activities focus on ensuring that members from these agencies understand the levels of impact they have on youth suicide, including: prevention, crisis intervention, "postvention" and ongoing education. Pueblo City-County's steering committee operates similarly, and likewise comprises more than 20 community agency representatives from the area including their RHC. In improved coordination of their community organizations, San Juan Basin Public Health (SJBPH) has convened an overarching steering committee and workgroups focused on responding to suicide in the individual counties (Archuleta and San Juan/La Plata). These committees comprise community agency members as well as community residents, who are suicide survivors. San Juan Basin also worked diligently to level-set and bring everyone at the table to the same collective understanding of differing agency and member roles in the region and positioned SJBPH to serve as the "backbone agency" in this effort while engaging all stakeholders to work together collectively.

We have seen an acceleration in implementation of program activities and continue to receive recognition and appreciation from the communities in which the LPHAs are working. Agencies are coordinating responses and strategies within their regions and working across SIM-funded agencies to learn from each other and adopt strategies that work well. The development of Let's Talk Colorado came out of the work of TCHD and five other SIM-funded LPHAs have worked with the program coordinators at TCHD to use the same materials and expand the campaign across the state. We anticipate higher levels of intra-agency coordination in AY4 and beyond.

SIM-funded LPHAs continue to consider and plan for sustainability of their activities. Key practices important to this effort are working to align their activities with other programs funded by a different grant or funding stream. For example, NeCHD has been using and promoting ManTherapy,[15] a program out of CDPHE's Violence/Injury Prevention and Mental Health Promotion (VIP-MHP) branch, as well as the PRD awareness

campaign, which was created by the Children, Youth, and Families Branch at CDPHE. This allows them to potentially use such materials in similar efforts even after SIM funding ends.

The use of advisory and steering committees across SIM-funded LPHAs is an integral element to sustainability of the funded population health activities. By building capacity to understand and respond more effectively across agencies in a community, the LPHAs are setting their communities up for success to take up the mantle of this type of work when the funding for SIM is completed, and they may have to take a step back from leading this charge.

Finally, the amount of coordination and networking occurring between SIM-funded agencies is building capacity among these agencies to form connections with other local subject matter experts across the state, as seen in the level of coordination with expanding Let's Talk Colorado. These relationships will continue to form and strengthen in the remaining time of the initiative and will allow agencies to leverage those relationships even after the grant period concludes.

Population health workgroup
This workgroup comprises 17 individuals from Colorado community, business and governmental organizations with subject matter expertise. It convenes monthly to provide expert input and feedback to ensure that SIM interventions improve health outcomes at the community and population level and align with other population health and SIM efforts in Colorado. This workgroup continues to provide input and work with TriWest, contracted SIM evaluator, to assess the population health effects of SIM.

In March 2017, CDPHE worked with the population health workgroup to begin an environmental scan and gap analysis of population level behavioral health initiatives in Colorado. SIM funded a CPDHE contract with the Denver office of Health Management Associates (HMA), a national health care consulting firm, to conduct the scan and gap analysis. The purpose was to identify efforts related to behavioral health, identify where efforts might be lacking, compare these findings with best practices in behavioral health prevention and promotion and use this information to drive future decision-making, resource alignment and program activities for the population health workgroup and the state. The scan and gap analysis concluded in July 2017. The workgroup used the scan to inform the design of a call to action (see ***Appendix H4***) to improving behavioral health in Colorado. This work began in September 2017 by contracting with HMA to gather input from workgroup members and key informants around the state. The document, which is published on the SIM website, includes recommendations for how Colorado can expand its work in population-based behavioral health with programs for prevention and promotion, distribution of funding, policy development and structure. It has been endorsed by the governor, approved by CMMI and will be used by the workgroup to drive future activities through the conclusion of the SIM grant and shape behavioral health improvement in Colorado in the next 15 years.

Population health data
SIM is committed to addressing social determinants of health by encouraging and requiring LPHAs to address health disparities in local communities. CDPHE already tracks, monitors and maps population health data and can break it down by location, zip code, age, gender, income and other demographic categories, depending on population health measure, to identify and understand issues related to social determinants of health. In November 2016, CDPHE launched its Visual Information System for Identifying Opportunities and Needs (www.colorado.gov/pacific/cdphe/vision-data-tool) data tool, which provides consumers with interactive data visualization to create and extract data reports. CDPHE and SIM have frequently shared opportunities for training and presentations on the VISION tool to encourage widespread use and encourage population health stakeholders to use it to guide their efforts.

Efforts focused on children and families
The CDPHE Children and Families Behavioral Health Integration Specialist co-facilitates the Community

Norms Workgroup, a group of early childhood leaders focused on strengthening community and social connection as a means to address stigma around help-seeking in parents and caregivers in tandem with Illuminate Colorado and the Essentials for Childhood Coordinator. The Community Norms Workgroup is developing a toolkit to strengthen community and social connection, which is expected to include:

- An infographic of data that informed the project;
- A description of how to use the toolkit and augment the tools to make them relevant to the audience's community;
- Case studies; and
- Additional materials and tools.

Stigma and help-seeking are topics that many SIM-funded LPHAs are addressing, which complements this work. Please see more information in the alignment with federal and state initiatives section.

In addition, the SIM-funded Children and Families Behavioral Health Integration Specialist co-facilitates a group of statewide early childhood leaders with Assuring Better Child Health and Development (ABCD), called *the Early Childhood Screening and Referral Policy Council* (Policy Council) bi-monthly. ABCD is the statewide expert on implementing best practices in screening and referral systems building efforts and is also engaged with SIM-funded LPHA efforts, particularly with Northeast County Health Department.

The focus of the Policy Council is based on a recommendation from The Young Minds Matter Policy Brief (See ***Appendix H5***) co-written in August of 2015 by leaders in the field of early childhood and partners in SIM, including: the Colorado Children's Campaign, Colorado Children's Health care Access Program, and Children's Hospital Colorado, stating that "more data are needed to enable policymakers to determine how many families access and use screening, evaluation and intervention services, as well as what information about the evaluation process gets back to the primary care setting and the family." To address this need, the Policy Council embarked on a pilot project with three communities in the state to better understand local efforts related to data collection in screening and referral processes around the following five data points:

1) Whether the child was screened;
2) The results of screenings;
3) Whether an evaluation was completed;
4) Whether the child entered into services; and
5) Whether services for the child were sustained.

This project includes an online assessment of current processes, and a facilitated in-person discussion to glean more information on barriers and potential solutions.

It is important to note that this work supports the SIM-funded pediatric and family medicine practices reporting on the developmental screening CQM through policy and systems change. Ultimately, the Policy Council envisions a statewide expansion of the pilot project to gain a comprehensive picture of barriers to screening, referral, and data collection to identify opportunities for policy change in Colorado. This aligns with the shared objective of improved screening, referral and access to services for children across SIM, Maternal and Child Health, Project LAUNCH and other stakeholders.

Additional SIM opportunities

Funding opportunities for BHTCs and LPHAs outlined above allow awardees to select evidence-based or research-informed strategies that best address community needs. Grantees have strategically aligned their activities with other non-SIM program activities, including maternal and child health, the Supplemental

Nutritional Program for Women, Infants and Children (WIC), Communities that Care, Aging and Disability Resources Centers (ADRCs) or their county health assessment (CHA) process to expand the reach of their SIM work and improve their community's health. The SIM-funded CDPHE team will continue to encourage program alignment and consideration of new needs within communities. SIM seeks out new partnerships and the opportunity to leverage emerging opportunities to advance SIM goals. In 2017, SIM staff assessed involvement or collaboration between local program coordinators for SIM activities and maternal and child health activities and will repeat this assessment in 2018 and 2019. The SIM-funded CDPHE team is talking with different agency staffers to gauge awareness and collaboration with SIM staff to learn best practices (if an agency has high levels of coordination) and disseminate them. SIM-funded CDPHE staff also work to align programmatic work in CDPHE, including participation in workgroups on mental health and substance use and teen suicide.

SIM staff will continue to partner with new and existing efforts to reflect the changing needs and health care landscape in Colorado to improve the overall health of the state and advance SIM goals.

Roadmap to improve population health

Colorado's population health activities summarized above provide a platform to leverage health care system strategies and broader public health goals and community efforts to improve population health in the state. Colorado's strategic behavioral health population health roadmap illustrates the work to improve the behavioral health and wellness of the population. Given that behavioral health affects the overall health of the population, our roadmap represents an inventory of behavioral health strategies that align with advancing SIM goals and represents opportunities to support Colorado's health delivery system and behavioral health integration efforts. These approaches are categorized into three approaches to prevention including traditional clinical, innovative patient-centered care and funding models and/or community-clinical linkages and community-wide approaches. The roadmap represents a more detailed overview of behavioral health priorities, strategies and work that can be leveraged to help achieve SIM goals. It was updated to reflect future SIM activities. Inputs include:

- Shaping a State of Health: Colorado's Plan to Improve Public Health and Environment 2015-2019;
- Colorado's MCH 2016-2020 Needs Assessment; and
- The State of Health: Colorado's Commitment to Become the Healthiest State.

These were selected based on their applicability to SIM and potential reach. The list is not exhaustive but is representative of Colorado's behavioral health population health work as it relates to SIM. The behavioral health population health roadmap is organized by priority area and identifies proposed strategies and approaches to meet the goals along with proposed indicators and metrics to track impact. Each strategy is classified into one of three identified approaches to prevention. SIM priority areas and associated strategies and metrics are presented in the table to demonstrate alignment of SIM with other population health efforts.

The roadmap serves as a guide for SIM activities for the time remaining in the initiative. Identified SIM goals, activities, and measures will be a part of the population health evaluation and contribute to the broader SIM evaluation. 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 SIM goals, strategies and measures. The roadmap allows SIM staff to monitor other population health efforts in the state that relate to SIM and tracking these efforts will continue for the duration of SIM. SIM-funded CDPHE staff will report on SIM-identified metrics and indicators to the SIM office on an annual basis.

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	Progress
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	On track. Not a chosen approach for SIM, but CDPHE's Maternal Wellness unit is focusing on this.
	Support efforts designed to increase access to high quality mental and behavioral health care	TBD	State PHIP	Traditional clinical approaches	On track.
	Develop and expand the behavioral health workforce	TBD	State PHIP	Traditional clinical approaches	On track. SIM Workforce Development leading effort.
	Change the reimbursement structure for mental health services by increasing incentives	TBD	State PHIP	Traditional clinical approaches	On track. Colorado's Accountable Care Collaborative (ACC) rebid addressing this.
	Promote best practice mental health integration in all publicly funded primary care	TBD	State PHIP	Innovative patient-centered care and/or community linkages	On track. Work of some LPHAs funded by SIM.
2. Increase the number of children in Colorado receiving age-	Identify and implement policy/systems changes that improve developmental	# of state agency leaders and statewide partners who develop and endorse key	MCH	Innovative patient-centered care and/or community linkages	On track. SIM LPHA work; work of MCH unit in CDPHE.

appropriate developmental screening and increase the number of children who are evaluated and who receive services among those with identified needs	screening, referral and services for children ages 10 through 71 months	recommendations for improved policies and coordination of services related to developmental screening, referral, and intervention services			
		# of statewide organizations or systems that implement developmental screening, referral and intervention recommendations	MCH	Innovative patient-centered care and/or community linkages	On track. SIM LPHA work; work of MCH unit in CDPHE.
	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	On track. SIM LPHA work; work of MCH unit in CDPHE and SIM staff within CDPHE.
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	On track. SIM LPHA work.
	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	On track. SIM LPHA work.
	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	On track. SIM LPHA work and work of SIM staff at CDPHE.

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	On track. SIM LPHA work; work of MCH unit in CDPHE and SIM staff within CDPHE.
		% of mothers who are appropriately screened and treated for depression	State PHIP	Traditional clinical approaches	On track. SIM LPHA work; work of MCH unit in CDPHE and SIM staff within CDPHE.
		# of providers and/or hospitals in Colorado that implement key PRD competencies into standard work	MCH	Traditional clinical approaches	On track. SIM LPHA work; work of MCH unit in CDPHE and SIM staff within CDPHE.
	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	On track. SIM LPHA work; work of MCH unit in CDPHE and SIM staff within CDPHE.
		# of Medicaid providers who screen pregnant or postpartum women for PRD	MCH	Innovative patient-centered care and/or community linkages	On track. SIM LPHA work; work of MCH unit in CDPHE and SIM staff within CDPHE.
		% 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	On track. SIM LPHA work; work of MCH unit in CDPHE and SIM staff within CDPHE.
	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	On track. SIM LPHA work; work of MCH unit in CDPHE and SIM staff within CDPHE.
3b. Reduce the burden of depression among men of working age	Reduce the stigma of seeking help for depression	# of Colorado men who access and use online therapy provider tools available at Mantherapy.org	State PHIP	Innovative patient-centered care and/or community linkages	On track. SIM LPHA work; work of VIP-MHP unit in CDPHE and SIM staff within CDPHE.
	Increase access to an online cognitive behavior therapy tool	Percent of men who report experiencing symptoms of	State PHIP	Community-wide strategies	On track. SIM LPHA work; work of VIP-MHP
	through access to the Man Therapy campaign and website	depression (an increase implies reduction in stigma)			unit in CDPHE and SIM staff within CDPHE.

		Number of Colorado visitors to Mantherapy.org	State PHIP	Community-wide strategies	On track. SIM LPHA work; work of VIP-MHP unit in CDPHE and SIM staff within CDPHE.
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	On track. SIM LPHA work; work of VIP-MHP unit in CDPHE and SIM staff within CDPHE.
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	On track. Not a chosen focus area for SIM. CDPHE's VIP-MHP branch, DORA, the Colorado Consortium for the Prescription Drug Abuse Prevention are addressing through pilot projects to improve PDMP access for providers.
		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	On track. Not a chosen focus area for SIM, but a focus area for CDPHE Children, Youth and Families branch and VIP-MHP branch.
	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 require~~	~~State PHIP~~	~~Traditional clinical approaches~~	Not a chosen focus area for SIM. DORA issued opioid prescribing guidelines, but not "pain
		~~continuing education on safe prescribing practices~~			management guidelines." There is no continued education that is required.

		~~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~~	Not a chosen focus area for SIM. Materials for clinical guidance around medical marijuana during pregnancy previously developed in 2015.
		# 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	On track. Not a chosen activity for SIM. Focus area for CDPHE VIP-MHP branch and the Colorado Consortium for Prescription Drug Abuse Prevention.
		# 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	On track. Not a chosen activity for SIM. CDPHE's VIP-MHP and Children Youth and Families branch are focusing on this objective. Of note: prescription drug training and marijuana education are separate program activities.
	Increase access to permanent disposal sites for controlled substances	# of permanent drug disposal sites for controlled substances	State PHIP & MCH	Community-wide strategies	On track. Not a chosen activity for SIM. Focus area for CDPHE's VIP-MHP and Environmental Health and Sustainability
					Division and the Colorado Consortium for Prescription Drug Abuse Prevention.

	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	On track. Not a chosen activity for SIM, but CDPHE's VIP-MHP is working on this.
Priority Area: Health Care Access, Coverage, Integration and Quality					
1. Align state and local public health with health care reform efforts to increase access to and utilization of health care and related services	Standardize and connect public health data systems to allow for appropriate electronic public health and clinical data exchange through the Health Information Exchange	Number of sites reporting successful ongoing submission of appropriate public health tracking data	State PHIP	Innovative patient-centered care and/or community linkages	On track. Not a chosen activity for SIM but CDPHE's Health Systems Unit is working on this.
		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	On track. Not a chosen activity for SIM but CDPHE's Health Systems Unit is working on this.
	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	On track. Not a chosen activity for SIM but CDPHE's Primary Care Office is working on this.
	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	On track. Not a chosen activity for SIM but CDPHE's MCH / HCP is working on this.
		% 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	On track. Not a chosen activity for SIM but CDPHE's MCH / HCP is working on this.
	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	On track. Not a chosen activity for SIM but CDPHE's MCH / HCP is working on this.

	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	On track. Not a chosen activity for SIM but CDPHE's MCH / HCP is working on this.
	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	On track. Not a chosen activity for SIM but CDPHE's MCH / HCP is working on this.
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	On track. Not a chosen activity for CDPHE SIM team; Workforce Development leading.
3. Improve health care coverage	Expand public and private health insurance	# of Coloradans who are insured	State of Health	Community-wide strategies	On track. Not a chosen activity for SIM but HCPF and Connect for Health Colorado continue to enroll members under the expansion.
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	On track. Focus area for HCPF and ACC.
	Support better behavioral health through integration	TBD	State of Health	Innovative patient-centered care and/or community linkages	On track.
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	On track. Focus area for HCPF and ACC.
	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	On track. Focus area for CDPHE's CHED and the Governor's Office of E-Health Innovation.

	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	On track. Focus area for HCPF; CDPHE coordinating efforts.
Priority Area: Healthy Eating, Active Living and Obesity Prevention					
1. Increase the percentage of infants who are ever breastfed, and exclusively breastfeed through six months	Develop and support policies and programs that protect, promote and support breastfeeding-friendly environments	# of hospitals designated as baby-friendly	State PHIP, MCH, Vision 2018	Innovative patient-centered care and/or community linkages	Not a chosen approach for SIM; focus area of CDPHE's ECOP team.
		Marketing and distribution of a toolkit of resources and training opportunities to strengthen breastfeeding support	MCH	Innovative patient-centered care and/or community linkages	Not a chosen approach for SIM; focus area of CDPHE's ECOP team.
2. Improve nutrition and physical activity environments for children younger than 18 years via early childhood education	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	Not a chosen approach for SIM; focus area of CDPHE's ECOP and HEAL teams.
centers and schools, especially those that serve low-income populations	Expand access to the child and adult care food after-school program	# of meals distributed	State PHIP	Community-wide strategies	Not a chosen approach for SIM; focus area of CDPHE's Nutrition Services team.
	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	Not a chosen approach for SIM; focus area of CDPHE's HEAL team.
3. Increase access to worksite wellness programs and to healthy foods and beverages in worksite	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	Not a chosen approach for SIM; focus area of CDPHE's HEAL team.

and government settings	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	Not a chosen approach for SIM; focus area of CDPHE's DPP team.
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	Not a chosen approach for SIM; focus area of CDPHE's HEAL and OHE teams.

SIM-Specific Activities					
	Proposed Approach/Strategy	**Proposed Metric/Indicator**	**Source**	**Level of Impact**	**Progress**
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	On track.
	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	SIM	Traditional clinical approaches	Complete

	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	Complete
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	On track.
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	On track.
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	On track.
	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	SIM	Community-wide strategies	On track.
	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	SIM	Community-wide strategies	On track.
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	Complete
	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	Complete
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	On track.
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	On track.
	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	On track.
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	On track.
	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	On track.

d. Health information technology (HIT)

HIT end state vision

During award year 3 (AY3) of the SIM grant, HIT stakeholders continued to advance the SIM Operational Plan. The primary drivers for this are the SIM office, Office of eHealth Innovation (OeHI) and the Health Information Office (HIO) of the Department of Health Care Policy and Financing (HCPF). The SIM Office expanded on prioritized use cases developed in AY2 and the electronic clinical quality measurement (CQM) implementation roadmap produced in AY 3.

SIM's AY4 HIT operational plan focuses on the secondary drivers related to the two key use cases identified and prioritized by SIM stakeholders to advance service delivery and payment reform:

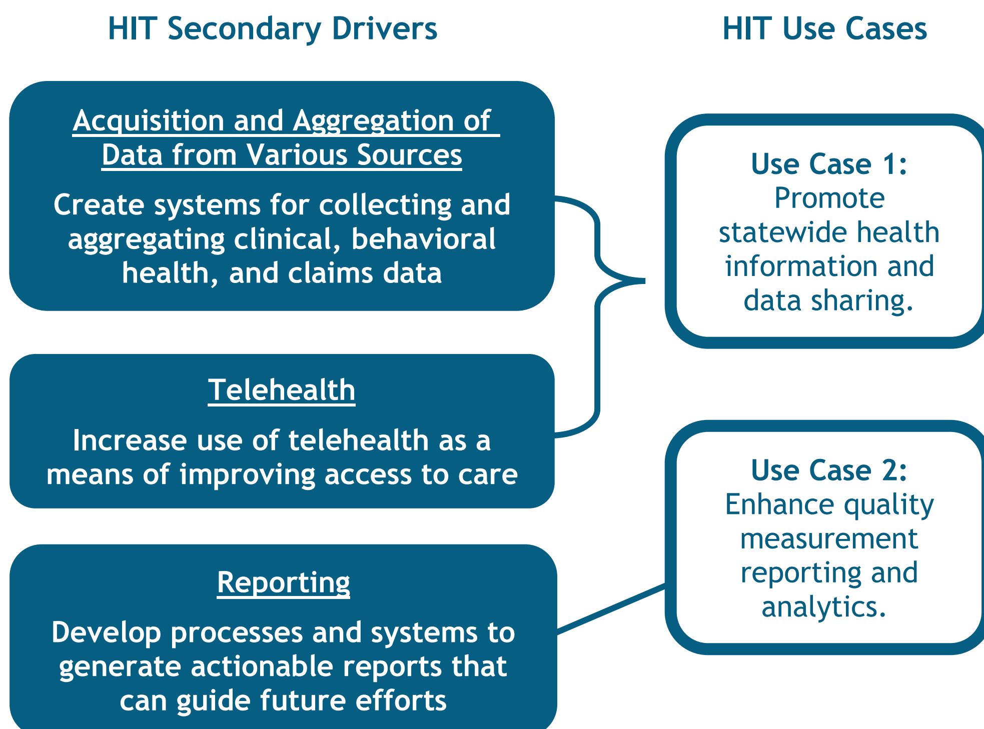
Use Case 1: Promote statewide health information and data sharing.
The exchange of health information, including behavioral health information, across providers lays the foundation for the advancement of improved health outcomes at lower costs across the state.

Use Case 1 focuses on broadly sharing health information across the state by increasing health information exchange (HIE) connectivity and establishing enterprise-level infrastructure to continue to advance through the state's clinical and claims data acquisition and aggregation from various sources, and telehealth efforts.

Use Case 2: Enhance quality measurement reporting and analytics.
SIM continues to make significant efforts to align and advance the reporting and measurement of CQMs.

Use case 2 provides SIM practice cohorts with an opportunity to advance methods for extracting and reporting CQMs beyond the manual entry of numerators and denominators.

The following figure represents the relationship of the HIT secondary drivers to the prioritized use case 1 & 2.



The tools and solutions facilitating SIM's AY4 operational plan and execution of the drivers are included in the below. For ease of reference, the table below provides a cross reference to demonstrate how the SIM tools described in the end vision below map to the drivers.

	Acquisition and Aggregation of Data from Various Sources	Reporting	Telehealth
eCQM	•	•	
MuleSoft HL7-FHIR API	•		
SPLIT	•		
Stratus	•		
Telehealth / eConsult			•
Broadband Expansion	•	•	•

Electronic Clinical Quality Measures (eCQM) registry

The eCQM solution will automate the extraction of field-level clinical data from the electronic health record (EHR) of SIM practices for eCQM calculation and validation. It will be developed on a technical framework that enables re-use of extracted field level source data. This data will be leveraged to automatically calculate CQMs and provide the foundation for future use cases.

The solution will receive source data from EHRs and potentially other sources (flat files, registries, ADT, HIEs, the All Payer Claims Database (APCD), payers, social determinants of health (SDoH), lab vendors and other data sources), extract the appropriate data and synthesize it to accurately calculate eCQM numerators and denominators. Once calculated, the eCQM solution will relay extracted eCQM numerators/denominators in an industry standard format to the State's Enterprise Service Bus (ESB) for Medicaid, the Shared Practice Improvement Tool (SPLIT), and potentially CMS and other interested commercial payers.

In addition to the technology and infrastructure, technical assistance will need to be available to SIM practices for CQM reporting and process improvement activities. To create trust in the extracted CQM data, practices need to be able to validate that the data being extracted from their EHR is high quality and

trustworthy. A unique aspect to SIM's validation efforts is the creation of feedback reports to practices that help enumerate the quality and completeness of the extracted data for a given measure. For example, in the case of The Substance Use Disorder, Tobacco measure (CMS 138), the data associated with this measure in the eCQM feedback report might show that some of the data elements for measure calculation are missing a value on a certain percentage of patients thus preventing those patients from being included in the numerator or denominator. This feedback report gives the practice and eCQM vendor the ability to ascertain if the data gap is related to technical mapping issue in the measure extraction process, a backend issue with how the certified EHR is coding the measure elements or an end-user workflow issue in the source EHR. A very important aspect in this process is the handoff to the practice clinical health information technology advisor (CHITA) from the eCQM vendor if the issue is related to a workflow in the source EHR.

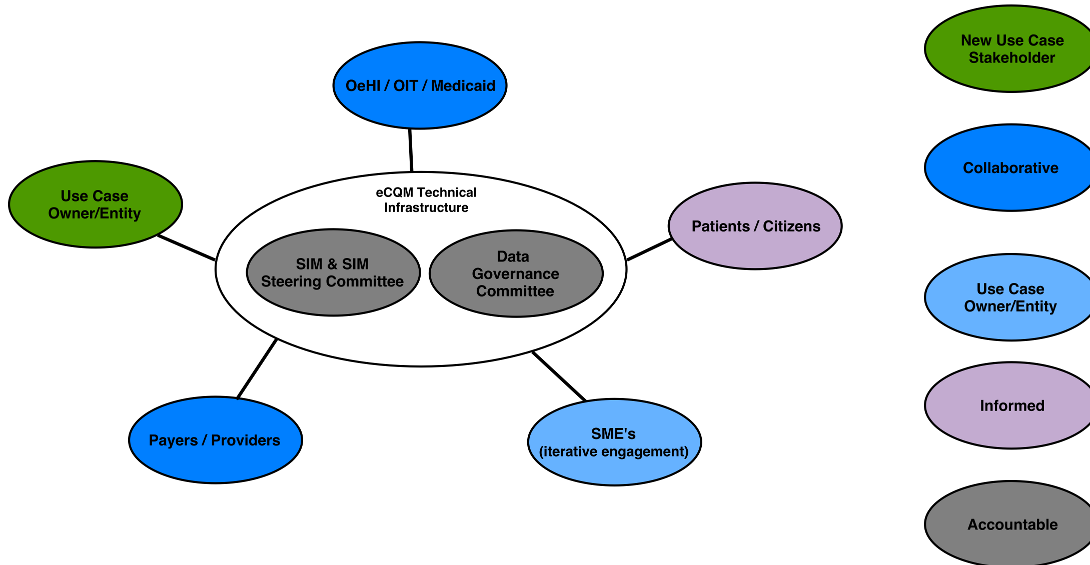
SIM has also contracted with HealthTech Solutions (HTS) to provide technical subject matter expertise to the eCQM vendor as the eCQM solution is created. HTS was selected in part because of the eCQM work the company did with the state of Idaho and the company's in-depth experience with creating similar reporting solutions for other states.

eCQM Governance

SIM will use a phased approach to implementing organizational and data governance. Stakeholders believe a phased approach is critical to long-term sustainability. In AY3, SIM, with assistance from Public Knowledge, a consultant, met with key stakeholders to identify the following guiding principles for the eCQM solution's operational governance and data governance structure.

1. Build and establish trust with stakeholders for establishing and using quality measures.
2. Understand and communicate how data will be used.
3. Promote transparency and buy-in across payers and providers.
4. Promote scalability and continually communicate about the roadmap.
5. Provide an appeals process for providers that may not agree on the measures.
6. Promote knowledge transfer and how to use measures.
7. Give stakeholders an opportunity to understand data uses and limitations.
8. Create and update use cases as eCQM evolves.
9. Share minimum necessary information to meet eCQM objectives.
10. Reduce provider burden and increase trust of the measure by the recipient.
11. Must have a rigorous measure validation process for measures across providers, payers and recipients.
12. Promote "public utility"/ services.
13. Ensure the governance model is iterative.
14. Provide a feedback loop for communications.

In alignment with the guiding principles, SIM is establishing its foundational eCQM governance committee to address immediate implementation needs of the eCQM solution. Once the initial use case is operational, the focus will turn to expanding the governance framework for sustainability of the solution.



The foundational governing body will remain small and nimble to quickly execute decisions. SIM is leveraging stakeholder groups already assembled: the SIM Advisory Board, OeHI, HCPF's Health Information Office (HIO), the SIM HIT workgroup and HIEs.

The governing body's role is to complete one-time efforts that are focused on setting up the necessary model to work on the initial eCQM-specific use cases. SIM has engaged the Colorado Health Institute (CHI) to leverage legal framework efforts, resources and expertise to support the operational governance of the eCQM solution. Members of the HIEs and the OeHI staff serve as advisors and inform the direction of the eCQM governance, however they are ex officio and do not have voting privileges. CHI will facilitate and assist SIM with the administration of the foundational governance process through the end of SIM and will transition the operation of the eCQM governance to OeHI, which will expand the infrastructure to support statewide CQM reporting along with the Statewide eHealth Commission.

MuleSoft HL7-FHIR

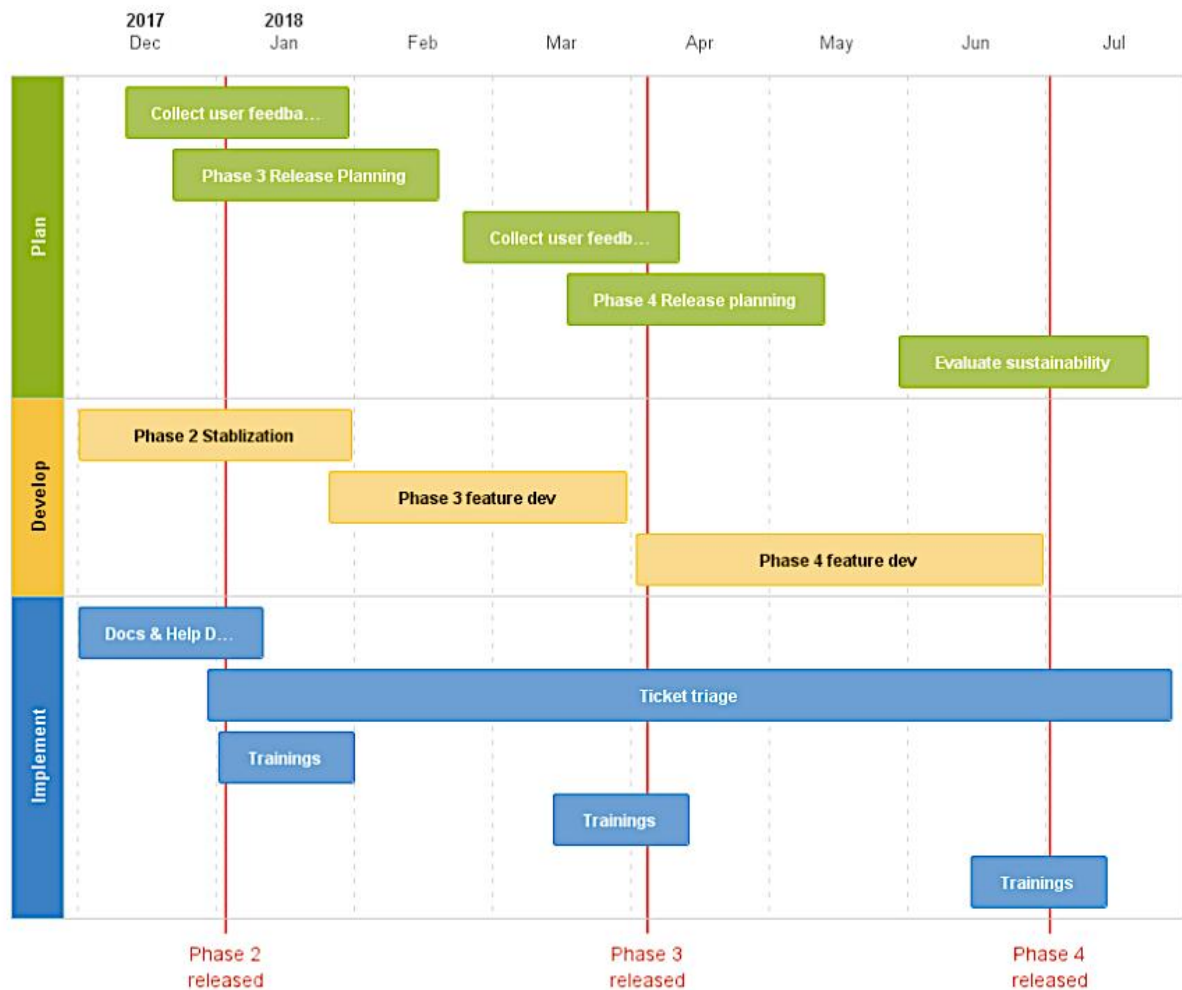
SIM will add HL7-FHIR connector to the state's existing MuleSoft Enterprise Service Bus (ESB) to establish the underlying infrastructure for delivering eCQM numerators and denominators to Health First Colorado (Medicaid). This functionality will also add the capability to share HIPAA sensitive data and other data types between state agencies and the HIEs. It will provide the first bi-directional data sharing platform for the state and HIEs and can be leveraged for future use cases. FHIR is a standard developed by HL7. The FHIR Connector MuleSoft will support use of APIs to promote interoperability across HIT stakeholders in Colorado. The use of HL7-FHIR aligns with the 21st Century Cures Acts Trusted Exchange and Common Agreement (TEFCA) provisions that will be finalized in AY4.

Shared Practice Learning and Improvement Tool (SPLIT)

SPLIT serves as the primary location to input and store practice information, assessments, notes and progress. SPLIT keeps track of how well health care teams perform on key building blocks of advanced healthcare delivery. The tool is designed to help health care teams identify their strengths, recognize areas of need, and prioritize their work in practice transformation and quality improvement. SIM will expand the

service to all SIM cohorts.

For providers and entities that are not tied to one of Colorado's HIEs, the AY4 plan for SPLIT is to continue providing a manual interface for entering numerators and denominators into Medicaid's Advance Payment Model tool. SIM will support the extension of SPLIT, which provides a front-end collection tool for entities manually entering CQM data. SIM will work with the University of Colorado Department of Family Medicine (UCDFM) to develop and support SPLIT for current and future uses.

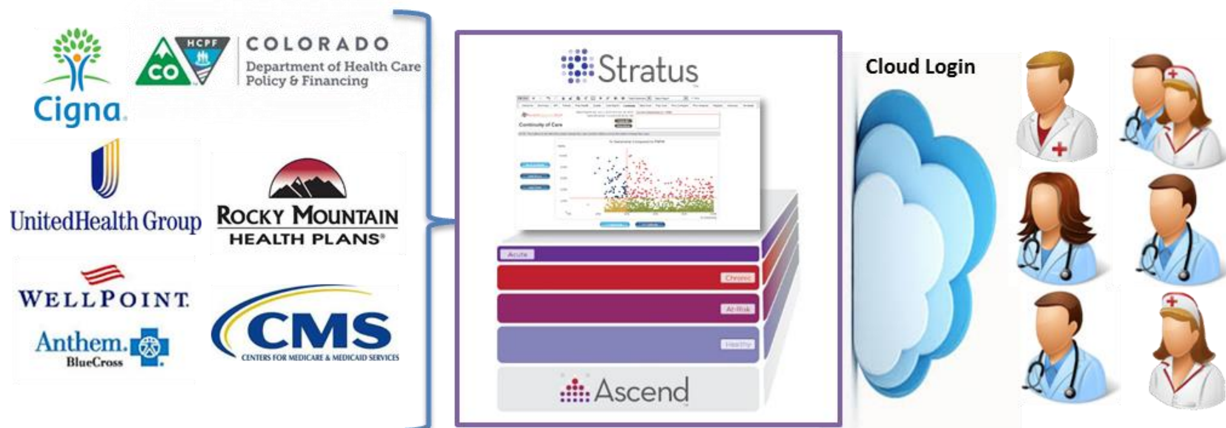


SPLIT functionality is being enhanced based on program needs. Once enhancements are released, practice transformation organizations will be trained on new functionality and workflow. Practices are able to manually submit numerators and denominators that can be aggregated and used for CQM reporting.

Stratus™

This analytic software package was designed to provide physician practices and care management administrators with patient-centered, population health insights aimed at improving health systems results. The scope of Stratus™ is to support informed decision making needed as providers assume more risk. Success requires additional information related to quality, coordination of care, medical costs, patient risk and population health.

Stratus™ seeks to solve several issues with the health care system. Gleaning information from data is a complicated process, due to a lack of organized data in primary care. Often the data is storied across several unintegrated locations. Practices have slim resources to interpret and integrate data even before they need to analyze risk.



The value SIM saw in Stratus™ is its ability to provide powerful insights to complex data sources. The application was developed to optimize the adoption of the following principles:

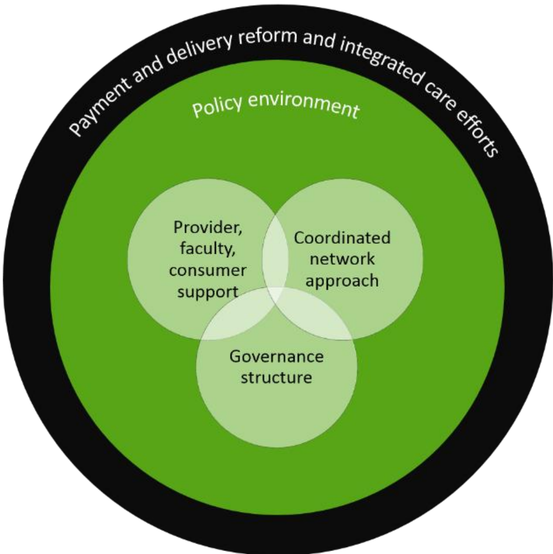
- Make information easily accessible;
- Channel users toward opportunities and action;
- Enable users to independently consolidate, search and visualize their data;
- Provide a simple, mouse-driven application without the need for requiring SQL knowledge;
- Require minimal user training;
- Dynamically associate data; and
- Quickly identify organizational goals.
- The application is flexible through its ability to adapt to and accommodate multiple data sources. Below is a list of common data sources queried by the application. If Stratus™ does not have a given data source, it will utilize the remaining available sources to produce the most effective insight for the user. The types of data sources include:
- Claims data;
- Prescription data;
- ETG data;
- Pharmacy Claims; and
- External Lab data

Telehealth / eConsult

The vision for a statewide strategy for telehealth supports the SIM goal by using telehealth as a facilitator, expanding its use, adoption and uptake to support increased access to integrated care supported by payment and delivery reform. In this vision, patients access the telehealth system through various entry points such as a primary care facility, hospital, emergency room, community mental health center, at home or via a mobile device. The SIM office worked with stakeholders across the state to prioritize funding. There is a lot of ongoing investment already in telehealth across Colorado.

A robust stakeholder-driven process illuminated several key strategies necessary for a coordinated

approach to telehealth expansion. Several potential leverage points, or actionable strategies to operationalize the vision, have been identified. These five final strategies, as illustrated by Figure 1, work in concert and combine in a broader system change framework.



Three of the strategies are structural in nature:

1. Establish a governance structure;
2. Support a coordinated network approach; and
3. Establish provider- and consumer-specific support centers.

The final two strategies work to affect the overarching environment in which the strategies are operating and support the structural changes:

4. Ensure the policy environment is supportive of telehealth; and
5. Leverage and integrate existing payment and delivery reform and integration of care efforts.

Collectively, these strategies support a vision in which telehealth improves access to integrated care in several key ways, regardless of setting or reason patients are seeking services. It will change the structure of the system by creating a coordinated network approach, supporting investments made in telehealth infrastructure and provider training while supporting continued expansion across the state. One of the key strategies is to increase information, which will ensure providers in the networks have adequate support and training and recruit and cultivate providers, providing information and resources to overcome barriers to entry. It will also grow capacity of the system by increasing the size and connected capacity of the telehealth network facilitating integrated care through coordinated networks, thereby increasing access to care.

During the no-cost extension (NCE), a subject matter expert group was convened biweekly to provide actionable recommendations to the SIM office on how to invest in the strategies highlighted above. The SIM Office expected to release a Request for proposal (RFP) for the statewide telehealth solution in October 2017, but there was not enough information to release an RFP that wouldn't result in funding unsustainable pilots. The SIM team pivoted the strategy to focus on collaborating with Medicaid and aligning with Medicaid's priorities to ensure the strategy would be sustainable through support from the largest payer in Colorado. To further refine the strategy, SIM and HCPF stakeholders have done extensive work in AY3 through an Information Request and Options Analysis described further below.

Medicaid's priorities in telehealth are aimed at expanding eConsults, due to promising evidence of cost-savings and improved health care access in other states such as Oklahoma through the Doc2Doc study and in Connecticut through the Community eConsult Network (CeCN) implemented through the Weitzman Institute. HCPF implemented a pilot with primary care and rheumatology, which ended in 2016. HCPF and SIM are aligning efforts to support e-Consults. An e-Consult and referral program, developed with robust evaluation and quality metrics, can enhance appropriate access to specialty care while avoiding

unnecessary visits. This will enable the Colorado Regional Accountable Entities (RAEs) to better coordinate care for patients, who require in-person consultations. An essential component of this solution is to build capacity within the specialty networks in Colorado to serve the Medicaid population.

Due to these considerations, SIM will expand telehealth with a focus on eConsults to improve access to behavioral health and specialty care throughout the state. Extensive research was done into the state's telehealth environment with an environmental scan, gap analysis and survey and stakeholders ranked this as the best option in an options analysis. In aligning with Medicaid's priorities, we hope to ensure long-term sustainability of the telehealth/eConsult strategy.

The specific implementation model is still being discussed by stakeholders, who are considering two models. The first is to release an RFP for the expansion of existing eConsult networks through healthcare systems. The RFP for systems would require expansion beyond the existing networks by entering new care compacts with primary care practices in rural and underserved areas with a focus on practices that serve a high percentage of Medicaid patients. The second option is to build on the implementation of the RAEs. The specific models might vary but the funding opportunity would require RAEs to design an approach that focuses on expanding specialty access while improving capacity of primary care providers. Each RAE would be required to propose its eConsult model prior to release of the funds. Each proposal would capture the planned specialties and aspects of health care targeted through eConsults, the populations served and how each model would align with SIM goals. Through either model, vendors would enter into contracts with SIM, allowing SIM to define clear reporting and monitoring parameters, which would establish a process to measure outcomes throughout the funding cycle.

The statewide eConsults vision supports the SIM goals by expanding services to increase primary care capacity and access to specialists. It allows SIM to address gaps without trying to compete with existing referral patterns and will facilitate care coordination, while allowing investments already made in eConsult services to grow.

The plan to evaluate progress is outlined in the workplan.

Broadband Expansion

Providing broadband access to sites around the state will facilitate access to data required to supporting SIM's primary drivers.

In 2015, CTN and SIM set the goal of expanding broadband access to 300 healthcare sites during the three-year SIM grant period using the Federal Communications Commissions (FCC)'s Healthcare Connect Fund. Historically, the United Services Administrations Company (USAC), an independent not-for profit designated by the FCC to administer the funds, awarded funds on first come first serve basis and that meant CTN could apply for funding throughout the year. However, in subsequent years the funding application window changed. The Healthcare Connect Fund has a $400 million annual funding cap. Due to the popularity of the program, the funding cap was exceeded by $156 million in FY 2016. To accommodate the increased demand, USAC changed its funding request policy by only allowing staggered filing windows. The fixed period to file for funding requests usually starts at the beginning of the calendar year and it remains open for three months. With the new policy change, all submissions are treated as received at the same time.

This policy change coupled with USAC experiencing longer than usual times to process forms in lieu of the increased demand of the program and a slim staff initially effected CTN's timeline and SIM deliverable

goals for connecting 300 sites by mid-2019. However, in May of 2018 CTN received approvals from USAC for applications submitted during the last application period and is on track to expand broadband to 300 sites.

If the goal of reaching 300 sites is not achieved by quarter-1 2018, CTN proposes to submit a new deliverable for SIM to maximize accessing the funds allocated to CTN based on the budget request. The deliverable will narrate CTN's efforts to expand broadband across Colorado through collaboration with the Governor's Office of Broadband, Department of Local Affairs, local technology planning teams and local public health departments. In AY4 SIM has asked CTN to work with the newly created Colorado Office of Broadband to coordinate broadband expansion efforts in the state (see ***Appendix I1***).

Other supporting initiatives

A central component of SIM is the expansion of the state's HIT infrastructure to support the Triple Aim. As SIM works to create a fully-integrated electronic health care system with a statewide reach, public and private collaboration will be essential to achieving our goals. This work could not be accomplished without close alignment and coordination across state agencies and HIT stakeholders to leverage existing and available resources. The Office of eHealth Innovation (OeHI), the SIM office and HIO meet weekly to coordinate project plans and identify funding opportunities for shared HIT objectives.

OeHI, like the SIM office, is housed within the Governor's Office to promote partnerships and leadership input. OeHI plays an important role in strengthening public-private collaboration on HIT initiatives. OeHI is tasked with promoting and advancing the secure efficient and effective use of HIT and coordinating "relevant public and private stakeholders and HIT programs across state agencies and between state and federal projects."[16] OeHI, advised by the eHealth Commission, is Colorado's state-designated entity (SDE) for the advancement and implementation of the American Recovery and Reinvestment Act (ARRA) Health Information Technology (HITECH) federal funds. The Department of Health Care Policy & Financing is the fiscal agent for SIM and OeHI. Public and private collaboration and coordination will figure prominently in several of the SIM HIT initiatives.

OeHI, in partnership with SIM and HCPF, has prioritized several key initiatives to advance Colorado and they are reflected in Colorado's Health IT Roadmap. This three- to five-year strategic plan leverages crucial work established through SIM, the Transforming Clinical Practice Initiative (TCPi) and other transformative efforts. OeHI is in the process of requesting state funds for federal match of several of these initiatives, which are described in the following sections.

Implementation Advanced Planning Documents (IAPD) are being updated and submitted to CMS for approval of federal matching funds to cover provider onboarding. It also supports strategic development and implementation of core infrastructure and technical solutions, as mentioned in Colorado's Health IT Roadmap, to create and enhance sustainable EHR solutions for Medicaid providers. HCPF is in the process of submitting an annual IAPD-Update (IAPD-U), which aligns HCPF's strategy for advancing HIT and HIE in Colorado. The IAPD supports the design, development, testing and implementation of core infrastructure and technical solutions promoting HIE for eligible professionals (EPs) and eligible hospitals (EHs) aligned with Colorado's Medicaid Electronic Health Record (EHR) Incentive Program authorized by the ARRA. Colorado's Health Information Exchanges (HIES) are essential components of Colorado's Health IT ecosystem. They continue to evolve and support sustainability of HIT for providers and communities. The following key initiatives are described in the statewide HIT Roadmap.

[16] https://www.colorado.gov/pacific/oehi/colorado-health-it-roadmap-0

Identity Management

Accurate information on a healthcare consumer is critical to care. OeHI, in collaboration with HCPF and other stakeholders, is planning to invest in an identity management solution to provide a common key identifier for clients. The solution will provide a more unified view of health care consumers improving the quality of data on populations served and overall service delivery. It will also leverage the MuleSoft HL7-FHIR connector to access HIE data on healthcare consumers. The state identified several initial use cases for identity management across data sources in the Medicaid enterprise and the Colorado Department of Human Services (CDHS). This includes identity matching among Colorado's Benefit Management System (CMBS), other human service systems and the Medicaid Management Information System (MMIS). Ideally, stakeholders will invest in an identity management solution as "as a service".

While initially starting with, and focusing on, solving the state agency needs, the scope for this initiative could ultimately be broader than the state's HIT infrastructure. Steps include:

1. Understand state agency needs and specific use cases
2. Procure and deploy a system to manage person identity that will be used across state agency systems.
3. Replace the current identity management solution for human service systems as part of the identity management solution.
4. Consider using the state's recognized master person identifier when communicating with state agencies
5. Develop an approach for implementing a common person identity that can be used by multiple systems statewide.
6. Consult with providers and consumers regarding what data should (or could) be used for harmonization
7. To help gain provider and consumer input, use statewide social advocates such as:
    a. Colorado Consumer Health Initiative
    b. Center for Patient Advocacy
8. Identify the benefits of a harmonized approach and use this information to educate providers and consumers.
9. Prioritize use cases.
10. Align and consolidate identity-matching approaches into a common statewide approach.
11. Leverage and align the approach with federal direction and capabilities/systems on statewide common services
12. Consider the use of biometrics for uniquely identifying a person.
13. Develop and implement tools and processes to support statewide identity matching.
14. Consider incentives to promote the sharing of health and health-related information.
15. Consider using the state's recognized master person identifier as a requirement when communicating with state agencies.

CDPHE Master Provider Directory

Colorado does not have a statewide provider directory. As a result, efforts are duplicated between the various health care entities to get up-to-date provider information. CDPHE has been working on a Master Provider Directory (MPD) and SIM's eCQM efforts will help CDPHE create an API that HIEs and other health care entities can use to verify provider demographic information. This program will allow a more timely provider identity resolution, which is needed for provider attribution use cases.

CDPHE's Primary Care Office is working on efforts for a health care provider directory. It will provide detailed information about practice patterns and network adequacy for insurers. The State is looking to

potentially leverage this solution for Medicaid providers and other providers. The following steps have been identified to support a statewide MPD:

1. Develop an approach for a common provider identity that can be used by multiple systems statewide.
2. Determine the various sources of information for provider identification, organization identification and relationships, providers, and patients.
3. Identify the benefits of a harmonized approach and providing a single "source of truth" for provider identify and relationships.
4. Develop and prioritize use cases.
5. Align and consolidate provider identity-matching approaches into a common Statewide approach.
6. Consider statewide use of the Provider Directory under development at CDPHE.
7. Develop a long-term sustainability approach.
8. Develop policies that drive the use of the provider directory.
9. Consider offering this as a utility or a service.
10. Consider mandating the use of this directory for all state-related business.

Consent Management

HIT stakeholders identified a need for consent management. This work complements the policy work that SIM is doing around 42 CFR Part 2 as described in the acquisition and aggregation of data from various sources section. The consensus process must support person-directed care. Consensus at the point of care is considered the most effective approach. However, the state may explore automated consent management tools as a service and will need to assess and update policies to support consent management. Steps to support consent by state stakeholders:

1. Identify variations in consents used around the state.
2. Obtain provider, consumer, legal, and other expert opinions as a foundation for developing the approach.
3. Leverage Colorado resources such as work done by CORHIO and QHN as sources for consent management.
4. Harmonize consents to develop common process/forms that can be used statewide.
5. Ensure that the process for obtaining consent is well-integrated into providers' workflow.
6. Incorporate behavioral health data when appropriate.
7. Consider creating incentives to adopt the statewide consent approach.
8. Research the consent processes that other states have developed for statewide use.
9. Include considerations for consent requirements for cross-state sharing of information.
10. Involve key stakeholders in coming to consensus around a consent approach that would be used statewide.
11. Provide education and outreach to providers and consumers relating to consent processes, options and the impact of data governance.

Data Governance

As part of eCQM and other efforts, SIM will support OeHI and other statewide stakeholders to form a data governance structure by taking these steps identified by state HIT stakeholders:

1. Create a multi-stakeholder advisory council with members from public and private sectors to advise on policy and other issues.
2. Prioritize which categories should be addressed early such as those which have a patient safety component, promote better patient care, and care coordination, apply statewide, etc.
3. Leverage Colorado efforts and organizations, such as: the eHealth Commission, Governors Data Advisory Board, SIM, QHN, CORHIO, CIVHC, health systems, clinically integrated networks

and managed care organizations.

4. Leverage state and federal policies and tools, such as: The Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act)5, Information Blocking Report,562017 Interoperability Standards Advisory,57Federal Health Architecture58.
5. Leverage current Colorado efforts and organizations, such as the State Joint Agency Interoperability Project59 and data sharing agreements.
6. Identify priority data issues and focus on standardizing key data elements across state agencies, then across the state.
7. Develop and implement a set of statewide standards, policies, and best practices for sharing of health and health-related data.
8. Develop a statewide recognized data format for longitudinal health and health-related data source(s).
9. Provide education on what data governance is and to what it applies.
10. Recognize that there are different norms for various kinds of data.

Acquisition and Aggregation of Data from Various Sources

Summary of AY3 Activities

Maximizing Health Information Exchange (HIE)

Onboarding SIM providers to HIEs for data submission continues to be a priority for the SIM HIT investment. SIM has approximately 75% of practices in cohorts connected to HIEs in varying degrees. Extending HIE services to SIM cohort practices has been important in promoting the secure and efficient exchange of data across providers and laying ground work for other key use cases, including increased data sharing and care coordination. The SIM office is working with the state's two HIEs, CORHIO and QHN, and HCPF to enhance state information exchange infrastructure and provide practices with more clinical information about their patients. SIM is also promoting the use of HIEs through the "Shared Cared" report pilot, which provides visibility into where a practice's patients are receiving care, regardless of practice connection to a HIE.

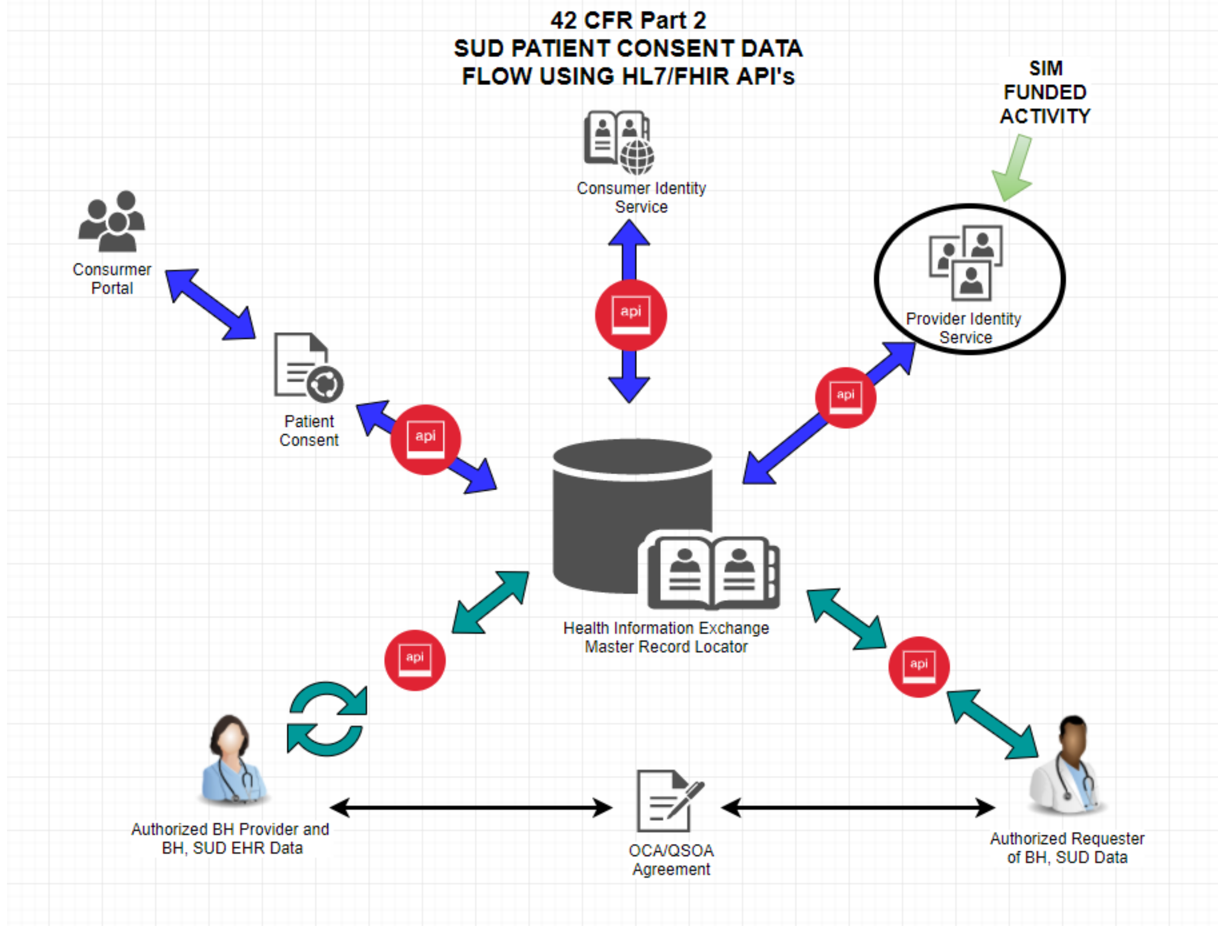
This level of connectivity is a significant challenge and the state of Colorado is committed to working collaboratively with CORHIO and QHN to advance the broad sharing of health information. Colorado is leveraging HITECH funds for onboarding providers to bridge this gap by paying for onboarding fees; however high costs of system interfaces, practice resources and ongoing HIE subscription costs requires additional consideration. Advancing information sharing by leveraging HIEs is one of the core components of SIM's Use Case 1, and an objective of the broader Colorado Health IT Roadmap described in Section 1.7 above.

To ensure integrated health information is shared broadly, especially with restrictions from 42 CFR, consent management is needed. In 2015, HCPF was awarded the ONC Advanced Interoperability grant for the two state HIEs to pilot different methodologies for behavioral health consent management to enable sharing substance use data. The "Shared Care" report pilot also promotes harmonized consent for information sharing regardless of practice connection to a HIE and reducing the need for individual practices to request access to data for the same client. During the pilot, HIEs provided independent workflows to obtain patient consent. QHN's workflow for obtaining provider consent with the patient present proved to be more effective than CORHIO's workflow using a portal and login for patient consent.

Consent management is included on Colorado's HIT Roadmap. Consent per SAMSHA regulation requires a patient to grant, revoke and to be able to see who has accessed his or her substance use (SUD) data. To achieve these requirements these components are required:

1. An up-to-date list of health care providers the patient can select.
2. An up-to-date list of people who would be granting consent.
3. A centralized location to store the who, what, when around the consent process.

SIM is working with several entities including OIT, CDHS, and OBH to establish the technical infrastructure required for meeting the 42 CFR Part 2 consent requirements. Although SIM is not directly responsible for coordination of this work, part of the OIT MuleSoft infrastructure that will be used for the eCQM extraction and reporting functionality will be used to establish the provider identity services for consent management. The graphic below represents the conceptual data model for consent management.



In AY3, CORHIO completed a pilot to assess the feasibility of taking data from HL7 and CCDA formats and merging them into a single document that would allow users to pull out discrete data points. CORHIO's pilot ended with the procurement of Diameter Health for the extraction and normalization of longitudinal CCDAs from EHRs and using the data from the same CCDAs and other data in the HIE for eCQM reporting. QHN is expanding the use of its Mirth infrastructure to achieve the same eCQM reporting functionality.

The eCQM data governance committee will establish the governance structure for the aggregated CQM data created through the eCQM solution. A team at the Colorado Health Institute is guiding this work with the SIM team. The initiative's overall governance is driven by the SIM advisory board with guidance and direction provided by the HIT workgroup.

Data aggregation

The aggregation of clinical and claims information is a core component of the SIM operational plan. As mentioned earlier, SIM is taking a phased approach to the aggregation of clinical and claims information due to stakeholder input, efforts underway through the Colorado HIT Roadmap and investment by multi-payers in a process and solution to help Comprehensive Primary Care Plus (CPC+) and SIM practices understand performance measures required for value-based payments.

The MPC includes public and private health care payers working to strengthen primary care. Established in the spring of 2012, the MPC originated as part of the Centers for Medicare & Medicaid Service (CMS) Comprehensive Primary Care (CPC) initiative. At its inception, the MPC consisted of 10 payers, regional and national, public and private, working together to coordinate efforts and support CPC practices. The MPC includes a majority of public and private payers in Colorado and is committed to building on initial efforts to expand and support primary care transformation in the state. The MPC is focused on supporting CPC, SIM, CPC+ and regional data aggregation and is convened by the Center for Evidence- Based Policy out of Oregon Health Sciences University.

The SIM office has partnered with the MPC to use Stratus™ during the SIM initiative to provide aggregated cost and utilization data to cohort practices to better understand cost, utilization and gaps in care to advance value-based payments. Additionally, Stratus™ can calculate Healthcare Effectiveness Data and Information Set (HEDIS) claims-based measures. This data sharing is essential for understanding population health needs and gaps in care. The SIM office contracted with Best Doctors to provide this tool to cohort-1 practices for one year in AY2. In AY3, SIM collected business, technical, and functional requirements to procure a claims data aggregation tool for cohort 2 and 3. The solicitation resulted in a sole source contract award to Best Doctors for continued use of its Stratus™ tool.

In addition to supporting data aggregation of claims data, the MPC has initiated a clinical data integration pilot using state HIEs to send three eCQM data points to Stratus™ to integrate with cost and utilization data. This pilot is facilitated by Rocky Mountain Health Plans (RMHP) and outside the scope of the SIM initiative, though the team is watching closely and will keep CMMI updated. This pilot includes practice representatives, HIE representatives, Best Doctors and a facilitator from RMHP. The hope is this will provide a platform that enables practices to access clinical and claims data in one place and use it to inform decision making. While this pilot continues, we have no additional information to report.

Governance: The MPC has developed several policy and governance policies to guide effective aggregation and data sharing for CPC+ and SIM. The governance panel comprises one payer representative and one alternate from each payer partner supporting data aggregation as well as a SIM office representative. Each payer organization has one vote in decision-making processes. Vendors and other contractors do not vote. The governance panel is intended to provide management, operational guidance and oversight for Stratus™. The objectives of the governance panel are to ensure project deadlines are met, make decisions regarding changes to Stratus™ and identify strategies for improving use of data regionally. The panel is informed by MPC meetings, the data workgroup and user subgroup. It has decision-making authority for Stratus™.

The data workgroup, which meets quarterly and is facilitated by Best Doctors, comprises payer and practice representatives with Stratus™ licenses. This may include members of payers' data and project management teams, practice care managers or data specialists, and providers. The objectives of the workgroup are to provide feedback on user experiences, discuss opportunities to improve Stratus™ and support practice use, and identify innovative project solutions to drive the use of data regionally. The workgroup operates with the following core principles:

- Communicate clearly, coordinate closely;
- Make data accessible to and actionable by CPC+ and SIM practices;
- Build on existing market resources;
- Focus on the goal and stay grounded;
- Achieve business requirements; and
- Explore multiple approaches, test, and innovate.

The data workgroup provides the data governance panel with recommended changes but does not have decision-making authority or oversight of Stratus™.

In AY3, SIM developed business, technical, and functional requirements for procurement of an eCQM registry solution to provide aggregated clinical data to cohort practices. The results of this solicitation resulted in a sole source contract award to CORHIO as the lead HIE with subcontracting support from QHN and Colorado Community Managed Care Network (CCMCN) to support clinical data aggregation. As described above, SIM is finalizing the eCQM Foundational Governance and has established the parameters for development of a single aggregation program starting in May 2018. Under this program, CORHIO will automate the collection of numerators and denominators for one CQM for all SIM providers connected to the two HIEs.

In AY3, SIM purchased the MuleSoft HL7-FHIR connector to support sharing of HIPAA-sensitive, and non-sensitive data between state agencies and the HIEs. The FHIR connector features pre-built Application Programming Interfaces (APIs) and an architecture to shorten the time it takes to facilitate the transfer of HIPAA protected and non-protected data between entities.

AY4 Plan to achieve in final SIM Year

In AY4 the team will continue to focus on working with SIM providers, Health First Colorado, commercial payers and other data sources to provide clean, quality, trustworthy data that can be used to advance payment reform, and measure and track the quality of health care services being provided in the state. To achieve this, SIM will continue to expand its investments in the eCQM, SPLIT, Stratus, and MuleSoft HL7-FHIR.

eCQM planning and development activities for AY4 include:

Developing and establishing the eCQM solution is a key component to establish aggregated data for calculation of numerators and denominators for CQMs. AY4 activities will be focused on formalizing the foundational governance with the support from CHI, which brings governance processes, policies and artifacts from its work on Denver Public Health's Colorado Health Observation Regional Data Service (CHORDS) collaboration. CHORDS is a regional pilot project that uses EHR data to monitor public health trends and public health intervention efficacy. CHI's work with SIM will establish the governing policies, processes, rules, agreements and infrastructure for data sharing within the eCQM.

SIM and CORHIO's first eCQM Use Case is to automatically aggregate data to calculate numerators and denominators for the nine CQM measures that are manually reported through the SPLIT tool. The pilot will begin in May 2018 with the goal of have 90 providers' eCQM data automatically submitted into SPLIT by the end of AY3. In AY4 the goal is to enroll the remainder of SIM across all Cohorts into the solution.

Q3 2019 activities will be focused on transitioning the eCQM from the initial use cases to long-term sustainability and approving additional use cases.

Additionally, SIM will work with the HIEs to expand their technical assistance role to support data extraction and validation of extracted data in preparation for ongoing, post-SIM CQM data reporting activities

The SPLIT Tool planning and development activities for AY4 include:
SIM will collect PTO and practice user feedback on SPLIT and identify potential areas of improvement. SIM is formalizing a new process for reviewing and approving any new projects for SPLIT enhancements. Any new projects identified from PTO and practices user feedback will go through the new process.

To support PTO and practice feedback received in AY3, SIM will enhance SPLIT to include the integration of following:

- Tableau data analysis and visualizations;
- TCPi Learning Network communication and management (calendars, shared resource features, discussion forum, etc.);
- Cross-project Shared Practice Support Plans;
- Initiative training registration, attendance or completion (Collaborative Learning Sessions, e-learning, webinars, etc.);
- Practice progression tracking and dashboards (phase progression, milestone tracking, etc.); and
- Shared access to initiative partner and practice participation agreements and other document storage needs.

Stratus™ planning and development activities for AY4 include:
SIM is planning to leverage the Stratus™ tool and Best Doctors' expertise and in collaboration with the Center for Improvement Value in Health Care (CIVIC) to develop use cases for claims and clinical data aggregation use cases.

Medicaid and commercial payers have expressed their interest in continuing services after the SIM initiative ends. In AY4, SIM will engage stakeholders (Medicaid and commercial payers) to establish ongoing funding and create a transition plan.

The SIM office has hired a new data management specialist with a primary focus of increasing practice utilization of Stratus™. This person will act as a Stratus™ super-user and a resource for SIM practices and PTOs.

MuleSoft HL7-FHIR planning and development activities for AY4 include:
The MuleSoft HL7-FHIR connector will support use of APIs to promote interoperability across HIT stakeholders in Colorado. The use of HL7-FHIR aligns with the 21st Century Cures Acts Trusted Exchange and Common Agreement (TEFCA) provisions that will be finalized in AY4. During AY4, SIM and OeHI will also use the MuleSoft HL7-FHIR connector support a statewide approach to consent management that aligns and harmonizes the consents required for health information sharing in Colorado. This project draws on the lessons learned from the CII pilots to create a centralized consent solution for Colorado citizens.

In AY4 SIM will continue working to align measures with national programs like Meaningful Use and MACRA/MIPS.

How programmatic activities link to program drivers/goals
AY4 focuses on the implementation and integration of the solutions purchased with SIM funding.

Redevelopment of the SPLIT tool to improve features to support user experiences bolsters trust in the process, and trust with the data. In the end, this will promote adoption of SPLIT statewide and other CQM reporting tools. The MuleSoft HL7-FHIR connector facilitates the ability to collect data from additional sources. Additionally, eCQM and Stratus™ activities support the driver to create systems for collecting, aggregating clinical, behavioral, health and claims data.

How delivery system and payment reform is implemented

The eCQM, Stratus™ tool and SPLIT are integral to the acquisition and aggregation of data from various clinical and claims sources. With the eCQM and data aggregation solutions that SIM has funded and developed, the following results are expected:

- Providers share data with minimal effort.
- Payers trust the data and release performance-based payments.
- Behavioral and physical health providers can share data (with patient consent) to provide care that is appropriate and effective.

How SIM will integrate, align, and coordinate across various state initiatives

As mentioned above in Section 1.7, SIM and HCPF have collaborated to prioritize several key initiatives to advance the Colorado HIT infrastructure.

Colorado Health IT Roadmap	SIM Driver	SIM HIT Investment
Integrate Behavioral, Physical, Claims, Social, and Other Health Data (Initiative 4) Develop and implement holistic approaches to harmonize, prioritize and enable the integration and aggregation of relevant health information on an individual in a meaningful way.	Acquisition and aggregation of data from various sources	eCQM
Uniquely Identify a Person Across Systems (Initiative 14) Develop and implement a comprehensive approach – that includes both health and social services information – that will be used across Colorado to uniquely identify a person across multiple systems and points of care.	Acquisition and aggregation of data from various sources	MuleSoft HL7-FHIR
Unique Provider Identification and Organizational Affiliations (Initiative 15) Develop and implement an electronic approach that will be used across Colorado for uniquely identifying a health care provider and his or her organizational affiliations – and ultimately that provider's patient relationships.	Acquisition and aggregation of data from various sources	MuleSoft HL7-FHIR
Broadband and Virtual Care Access (Initiative 16)	Acquisition and aggregation of data from various sources	Broadband Expansion & Telehealth

Colorado Health IT Roadmap	SIM Driver	SIM HIT Investment
Develop and support approaches that lead to ubiquitous, redundant, reliable and affordable broadband access for health organizations and consumers.	and Reporting	

How SIM will implement or leverage HIT as an enabling strategy for multiple elements the plan:
SIM's "acquisition and aggregation of data from various sources" secondary driver is leveraged from existing state HIT technology investments. In AY3 through stakeholder interviews and under the recommendations of SIM's HIT workgroup the clear direction was to enhance the robust HIT technical infrastructure in the state and not create additional data silos. SIM HIT efforts have taken that direction and worked towards that goal inside the state entities. This direction has also been embraced by Colorado's two HIEs CORHIO and QHN.

How programmatic activities support a long-term, sustainable vision for SIM activities and objectives.
AY4 planning and development activities are performed in coordination with OeHI and HCPF, and all activities focus on sustainability.

eCQM
Once the eCQM initial use case is operational, and shortly before the completion of SIM AY4, OeHI will transition to an active role in governance over eCQM planning for the long-term and expansion to the state as part of the Statewide Health IT Roadmap Initiative. Once SIM funding has ended, OeHI will assume budgetary and programmatic oversight of this work in the form of general fund dollars and federal 90/10 matching funds. The foundational governance committee will have an expanded governance role with support from HCPF and the Office of Information Technology (OIT) will also be included in the eCQM solution transition plan.

SPLIT
Medicaid is building in the capacity to calculate measures within its Business Intelligence and Data Management solution (BIDM). However, there is currently not a connection point from providers to provide data for the numerators and denominator to BIDM. Once the SPLIT front-end has been expanded for SIM practices, it will also be available to Medicaid and therefore could potentially transition CQM numerators manually entered SPLIT to the APM. This is still under consideration. Furthermore, using Medicaid as the model, other payers could benefit

Stratus™
After establishing a plan for ongoing funding and transition with its stakeholders, SIM will transition the Stratus™ tool oversight per the designated plan.

MuleSoft HL7-FHIR
AY4's focus, with the help of SIM and OeHI's roadmap, will focus on developing a statewide approach to consent management that aligns and harmonizes the consents required for health information sharing in Colorado. This approach will be built on the MuleSoft HL7-FHIR investment.

Reporting

Summary of AY3 Activities
As previously described in Section 1.2.1, the eCQM automated extraction and reporting procurement resulted in a sole source contract to CORHIO with subcontracts to QHN and CCMCN to provide access to

their data. The approach to establishing the foundational governance model for eCQM was completed with support from Public Knowledge in February 2018. SIM has engaged CHI to facilitate the foundational governance process while leveraging their existing governance tools and artifacts.

Additionally, CORHIO received certification as a Qualified Clinical Data Registry (CCDR) in December 2017. One of the many features of CORHIO obtaining this certification gives CORHIO the ability to aggregate CQM data from different systems and report those measures on behalf of a provider. For example, if a primary care provider sends complex diabetic patients to an endocrinologist and that patient's lab data is in the HIE, CORHIO can use this data to report this measure on behalf of the PCP – achieving a more complete patient record and reducing the reporting burden.

AY4 Plan to achieve in final SIM Year

During AY4, SIM plans to use drivers from AY3 to support Use Case 2: Enhance quality measurement reporting and analytics. SIM plans to leverage SPLIT for integrating clinical and claims data and conducting reporting. Below are key tasks for AY4 related to SPLIT:

- Explore the expansion of SPLIT to include provider level reporting to the Colorado Medicaid Accountable Care Collaborative Program.

For provider reporting, SIM will provide baseline and benchmark reports of CQMs, cost, and utilization information to practices. SIM will provide practices with benchmark reports that compare practice with performance and train HIT advisors to support practices in accessing and interpreting benchmark reports. SIM will also work with stakeholders to determine fields that are most useful to include in for reporting back to practices.

Evaluate policy actions including, but not limited to: Subscription subsidies to health technology platforms that will help improve data sharing across public and private care settings.

How programmatic activities link to program drivers/goals

SIM and the eCQM Foundational Governance Committee will oversee CORHIO, QHN, and CCMCN on development and a phased implementation of the CQM data aggregation beginning in May 2018 and continue through the end of SIM in July 2019.

AY4 SIM will continue to enhance quality reporting by quality practices such as comparing measures with baselines during a period of time. SIM will also provide practices with a benchmark report that compares practice with performance of their peers.

The eCQM solution and SPLIT are initially focused on the numerator and denominator aggregation and reporting. Once implemented, the governing body will turn to expand reporting to support sustainability. The ability to provide a value proposition to health plans, integrated networks and providers should provide the foundation for financial sustainability.

How delivery system and payment reform is implemented

As with the other tools related to acquisition and aggregation of data, the eCQM solution is a key component to supporting SIM's Triple Aim through the creation of actionable reports that guide future statewide efforts. It provides visibility into the data that can measure:

- Better experience of care;
- Lower costs; and
- Improved population health

SIM plans to provide baseline and benchmark reports of clinical quality measures (CQMs) to practices. Provider engagement in clinical quality reporting will assist Medicaid and other insurers move toward incentive-based payments. ECQM is a launching pad for supporting value-based payments. For example, beginning in fiscal year 2021, eligible providers who see Medicaid patients and meet certain structural, CQM- and claims threshold-based measures can qualify for enhanced fee-for-service reimbursement from Medicaid. With the ACC and RAEs, clinical quality measures are tools to support payment reform and incentivize performance.

How SIM will integrate, align, and coordinate across various state initiatives

In preparation for the eCQM data aggregation implementation, SIM aligned CQM measures with Medicaid, CPC+ and the MPC. SIM's "reporting" secondary driver is also leveraged from existing state HIT technology investments, including the current HIE infrastructure. SIM is a key stakeholder in the integration of physical and behavioral health. SIM is also actively involved with analysis and scoping of the identity management solution described in Section X. SIM is also supporting the investment in FHIR for integration of various HIT investments across state agencies and partners.

Colorado Health Care Policy and Finance (HCPF) was recently selected to participate in an Opioid Data Analytics Cohort of the Medicaid Innovation Accelerator Program (IAP). Colorado SIM's Data and Evaluation Manager will participate with HCPF's data team and staff from the Colorado Department of Human Services (CDHS). Colorado's goal is to determine:

- What do the existing data sources illustrate about the incidence and prevalence of OUDs to leverage existing pathways to care?
- Which data are missing from our resources, so we can build a more robust infrastructure to complete the OUD pictures in Colorado?

How SIM will implement or leverage current HIT as an enabling strategy of the multiple elements of the plan

SIM's "Reporting" secondary driver is supported through the use of existing state HIT technology investments. This includes the existing HIE relationships.

How programmatic activities support a long-term, sustainable vision for SIM activities and objectives.

The foundational governance structure will transition to OeHI beginning about six to nine months prior to the end of SIM in July 2019. Data governance will transition from the initial use case to statewide.

As noted in the SIM program evaluation and monitoring section of this report, the SIM office continues in AY4 to work with The Center for Improving Value in Health Care (CIVHC) to provide Medicare data for Stratus™. A major component of this effort is CIVHC's participation in the Qualified Entity Program (QE). Once QE is achieved, SIM will be able to provide Medicare data to the practices via Stratus™.

Telehealth / eConsults

Summary of AY3 Activities

SIM dedicated AY3 to additional planning efforts to refine its HIT strategy for telehealth, due to lack of sufficient information to warrant the release of an RFP. To supplement the environmental scan completed in AY2, SIM continued to convene a group of subject matter experts to guide the work, completed a gap analysis, released an Information Request, and completed an options analysis. This additional information

gathering was necessary because the telehealth market is rapidly growing and changing while cost and health outcomes are not consistently demonstrated across the industry and there was no clear funding opportunity for SIM funds to move telehealth in the state forward.

To guide the telehealth strategy, SIM convened a group of subject matter experts, which included members who directed telehealth programs at various healthcare systems, providers who provide services via telehealth, and other industry leaders who have worked extensively in the field and have a deep understanding of the telehealth environment in Colorado. A list of the members is included below.

Name	Type of Member	Title	Organization
Sam Lippolis	Chair	Director of Telehealth	Centura Health
Sandra Fritsch	Member	Medical Director (Psychiatrist)	Pediatric Mental Health Institute, Children's Hospital
Peter Kung	Member	VP for Innovation and Virtual Health	Sisters of Charity of Leavenworth Health System
Charlie Lippolis	Member	Psychiatrist	
Kathy Osborn	Member	Director of Telehealth	Colorado Telehealth Network
Carrie Paykoc	State staff	State Health IT Coordinator	Office of e-Health Innovation
Neill Piland	Member	Former Director & professor Public Health	Institute of Rural Health, University of Idaho
Lori Raney	Advisory Member	Psychiatrist and Principal Consultant	Health Management Associates
John "Fred" Thomas	Member	Director of Telehealth	Children's Hospital
Brian Turner	Member	Deputy Director	Colorado Behavioral Healthcare Council
Rachel Hutson	Member	Branch Chief, Children, Youth and Families Branch	Colorado Department of Public Health and Environment
Jennie Munthali	Member	Section Manager, Children and Youth with Special Health Care Needs Section	Colorado Department of Public Health and Environment

The direction that resulted from the meetings of this group was to release an RFP to fund existing programs focusing on behavioral health integration using telehealth. This direction was highly at risk of funding only pilots that would have no sustainability beyond SIM funding. The SIM team pivoted to align with Medicaid's priorities to ensure sustainability beyond SIM. Medicaid is focused on expanding eConsults throughout the state to reduce costs and improve access to specialty care for its members. Medicaid ran an eConsult pilot in which a small number of primary care providers could bill for rheumatology eConsults through a platform developed by Medicaid and run by CORHIO. During the pilot, the Medicaid team learned a great deal and is interested in expanding eConsults because of promising cost savings and improved access to specialty care from other programs. In AY4, the SIM team will continue to meet regularly with Medicaid stakeholders involved in telehealth and eConsult program implementation.

A gap analysis was intended to add more detail to the environmental scan conducted by Spark Policy in AY2 and clarify a direction for SIM investment. Three paths were identified and have been discussed by the stakeholder groups in detail and are still under consideration.

With sustainability as a key driver, SIM identified the need to closely align the design of this model with HCPF partners to reduce potential policy and reimbursement barriers and ensure that incentives continue for providers to expand their programs beyond SIM funding. The statewide Information Request survey targeted health care providers, payers and other stakeholders and focused on telehealth and eConsults. We wanted to understand the issues that prevent providers from using telehealth and eConsult services, and what could be done to expand these services in the provider community. From payers we wanted to do understand what telehealth and eConsult services they support, as well as what statewide solutions they would support in the future. The question set was developed jointly by the SIM office and HCPF and was meant to inform the decision-making process. The final questions and format of the Information Request is published as ***Appendix I2***. The results reinforced the fact that telehealth is a rapidly expanding field in Colorado. The responses showed that there is a lot of confusion from providers around billing and reimbursement, and that not many people are familiar with eConsults. There was a great interest in expanding – both from providers and payers - but results did not lead to a clear path forward for SIM investment. The following figures show the barriers to telehealth and eConsults that Information Request respondents reported. The full review of responses is included in the ***Appendix I3***.

Barriers	Telehealth	eConsult
Concern with Financial Value	• Inconsistent among Payers • Concerns related to billing and reimbursement • Loss revenue or unable to see financial value • Costs to implement/establish in practice	• Process for billing over availability of codes • Low demonstration of outcomes by providers • General expression that specialists will lose revenue
Technology and Adoption	• Broadband • Inconsistent Platforms • Clunky tools	• Platforms lacking interoperability • Workflow adoption
General Misconceptions	• Perception • Public Awareness • Misconceptions around billing requirements (especially for Medicaid)	• Inconsistent understanding of what eConsults are • Lack of common definitions/terminology

The results of the Information Request were presented to HCPF and SIM stakeholders in January 2018 and used to narrow the telehealth strategy options being considered and help inform an options analysis with the group. SIM formulated options based on the previous work in the environmental scan, gap analysis, SME group input, survey results, and best practice research. SIM facilitated an options analysis with HCPF and SIM stakeholders to identify the most advantageous strategy. Stakeholders assessed options based on factors such as opportunity, alignment with SIM goals, conformance with best practice findings, long-term incentives for use, and overall risk to sustainability. The final options analysis results are included in the ***Appendix I4***.

The options analysis resulted in further refinement of the eConsult approach and stakeholders are deciding between two implementation models. The first option is to release an RFP targeted at healthcare systems.

The second option is to fund the RAEs by providing seven equal grant awards to the entities to plan for and expand eConsult networks within their regions. With either option, one of the requirements would be to create new care compacts with primary care providers in rural and underserved areas with a focus on clinics that serve a large percentage Medicaid. Either of these options have high likelihoods of sustainability since they invest in current infrastructure rather than "recreating the wheel" with a new pilot project. Finally, both options align well with Medicaid's vision and strategy for incentivizing eConsults throughout the state, further supporting its sustainability and success of these efforts. One concern with both options is that they will create a patchwork of incompatible systems across the state. To mitigate this, the SIM team will design a logic model of implementation based on the eConsult toolkit that was released by Blue Shield of California Foundation (http://econsulttoolkit.com/) that the systems or RAEs will follow. The SIM team has adapted an implementation logic model from the eConsult toolkit and will use the model to create the guardrails of the funding opportunity. The implementation logic model can be found in the ***Appendix I5***.

AY4 Plan to achieve in final SIM Year

AY4 activities are focused on developing and executing the necessary contract agreements with the systems or RAEs to support funding transparency and to measure funding goals and objectives. SIM is working with procurement and leadership to develop a contract that will require each system/RAE to specify its proposed plan for funds. This will provide a contractual base for SIM to monitor throughout the remaining year. As part of the contract, each vendor be required to work with SIM to define a set of measurable objectives that will serve as the basis for contract reporting. Each vendor will be required to demonstrate how its model aligns with SIM drivers, and provide SIM the opportunity to measure success of the programs as they relate to overall goals

Additionally, the SIM office will be working with HCPF on implementing internal policy changes that will allow for programmatic implementation of an eConsult model for Medicaid. Some examples of this work will include researching and supporting a budget request for Medicaid to open eConsult codes. The research would need to address payment levels for both primary and specialty care, potential for certifying eConsult programs (the platforms and networks would need to meet certain standards to be eligible for reimbursement from Medicaid), and identifying any regulatory barriers or opportunities that would affect this work.

How programmatic activities link to program drivers/goals

SIM's telehealth activities are the conduit to improve access to access to care through facilitating expansion of the eConsult model to focus on behavioral health and specialty care. Furthering SIM's Triple Aim for better experience of care and improved population health.

How delivery system and payment reform is implemented

The system/RAE eConsult funding opportunity will leverage each system/RAE's existing eConsult model and expand infrastructure. As a result, the delivery system and payment model will differ between entity. As part of the funding opportunity, each system/RAE will be required to detail its proposed model, including but not limited to:

- Specific services and specialties delivered through eConsults;
- Technical platform and capabilities that support the eConsult model;
- Value proposition and strategy for participant engagement;
- Funding and reimbursement strategy;
- Objectives and approach to measuring outcomes such as cost reduction, access expansion, and quality improvement; and

- Ability to accommodate eConsult/eReferral access for new care compacts with rural/underserved/high-Medicaid primary care outside of current network.

Systems/RAEs will develop an eConsult operating plan as a contract deliverable detailing its approach to implementing the expanded eConsult services, support or technology. The eConsult operating plan will also capture the System's/RAE's approach to billing and reimbursement, as well as incentives for participation. Systems/RAEs will be required to report regularly on progress against their plans as part of the executed contract.

How SIM will integrate, align and coordinate across various state initiatives

The eConsult funding model is being closely planned with HCPF partners to align with the state's Medicaid Accountable Care Collaboration initiative and goals to improve Medicaid member health while reducing program costs through a value-based payment model.

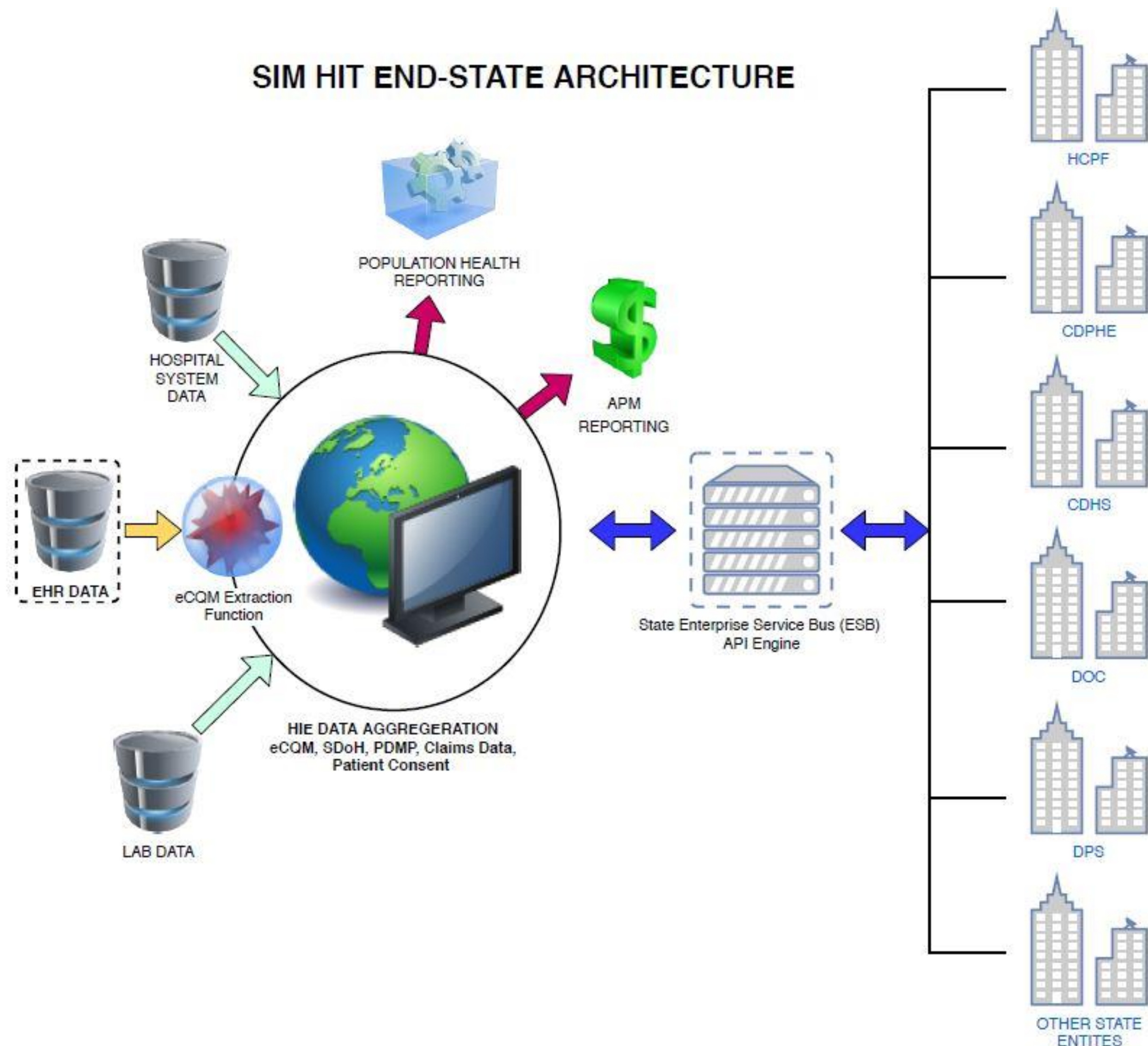
By allowing systems/RAEs flexibility in how they implement their eConsult models, SIM leverages existing provider networks and expands specialty services in both urban and rural areas of the state. Leveraging the RAEs strong focus on integrating physical and behavioral health also can expand access to behavioral health specialists, as originally planned in AY3.

In the 2018 legislative session the State of Colorado passed Senate Bill 17-019 to address the medication consistency for persons with mental illness in the criminal and juvenile justice systems http://leg.colorado.gov/sites/default/files/documents/2017A/bills/2017a_019_signed.pdf. This legislation provided planning funds to the Colorado Office of Behavioral Health (OBH) to research solutions and ultimately provide a report to the legislature in September 2019 on how this problem could be fixed statewide. SIM is participating in the planning portion of this work with OBH, OeHI, HIEs and OIT to leverage existing and future HIT investments to address the technology portions of what will eventually be a solution proposed to the legislature.

How SIM will implement or leverage current health information technology as an enabling strategy of the multiple elements of the plan

To mitigate risks related to sustainability, SIM will leverage existing eConsult platforms and provide additional support for each system/RAE to expand eConsult services that best align with their member and provider needs. To mitigate the risk of ending up with patchwork solutions that are incompatible, SIM will create an implementation logic model that all funded entities must follow.

As part of the funding opportunity, each system/RAE will be required to describe its eConsult model, planned services, as well as supporting technology and platform to facilitate the delivery of eConsults and related care. SIM funding may be used to further integrate eConsults into an EHR or existing technology or workflows to provide a more integrated care model. Regardless of the model, each system/RAE will be required to demonstrate how it will meet the goal of expanding capacity and access to specialists through eConsult technology.



How programmatic activities support a long-term, sustainable vision for SIM activities and objectives.
Sustainability was a key driver in the design of the eConsult strategy. Telehealth models have demonstrated mixed outcomes across the country, making sustainability planning even more important to the success of this program. SIM identified a strong link between sustainability and payer's long-term vision and strategy for telehealth and eConsult services. SIM partnered with HCPF to design a model that closely aligns with Medicaid initiatives in this domain.

The remaining activities are focused on developing and executing the necessary contract agreements with each system/RAE. Each funding agreement will require the entity to carefully detail its proposed plan for the funds. It should include an approach to how funds will be expended to improve existing eConsult services. It should also describe the sustainability model for provider capacity and specialist access. Based on industry research collected during AY3, SIM will work with each system/RAE at the contracting stage to incorporate sustainability best practices.

SIM will work with each system/RAE to define measurable objectives for building a successful and sustainable eConsult model. The resulting models will vary across the entities but will serve as a key

reporting area monitored by SIM throughout AY4. Systems/RAEs will report regularly on progress to the SIM team. Systems/RAEs will conclude with a final report at the end of the year measuring overall progress against the original baseline. SIM will use the findings to evaluate funding impact.

e. Workforce capacity

Stakeholder Engagement

A robust stakeholder engagement process is the foundation of SIM's workforce development efforts.

Workforce Workgroup

This workgroup regularly engages a wide range of experts representing organizations throughout Colorado, including academic medical centers, community colleges, professional associations and trade groups. Workgroup members represent the organizations listed below:

- Caring for Colorado Foundation
- Colorado Association of Addiction Professionals
- Colorado Children's Health care Access Program
- Colorado Department of Health Care Policy and Financing
- Colorado Department of Human Services, Office of Behavioral Health
- Colorado Department of Regulatory Affairs
- Colorado Department of Public Health and Environment
- Colorado Division of Labor and Employment
- Colorado Hospital Association
- Colorado Nurses Association
- Denver Health
- Greater Metro Denver Health care Partnership
- Jefferson Center for Mental Health
- Metropolitan State University of Denver, Department of Social Work
- Regional Health Connector, Region 18
- Red Rocks Community College
- Swedish Family Medicine
- University of Colorado School of Medicine
- University of Colorado, College of Nursing
- University of Denver, Graduate School of Social Work
- Well Being Trust

These members help guide the strategy and agenda of the workgroup and offer the SIM office powerful partnership opportunities to help advance initiatives that address training needs and workforce shortages throughout the state. For example, the SIM alignment with federal and state initiatives section outlines how the SIM office is supporting

Workforce & Education Workgroup

The SIM population health and workforce program manager sits on the Workforce & Education Workgroup, which consists of state agencies convened by the Colorado Department of Labor and Employment (CDLE) to align workforce needs with the educational system in Colorado. In AY4, the group will continue to look beyond traditional postsecondary education to programs such as registered apprenticeships, work- based learning opportunities and certificate programs to create a pipeline (for more information see 2017 Talent Pipeline Report) (See ***Appendix J1***) that is responsive to and meets the needs of the Colorado labor market. In AY4, the population health and workforce program manager will

continue to take findings from and issues raised by this group to SIM office staff and the workforce workgroup to guide implementation of initiatives.

Workforce Training

The state of Colorado is committed to developing an integrated behavioral health care system that will encourage practices to continue along the pathway to fully integrate behavioral and physical health in primary care settings. This change in status quo requires a different type of workforce. It is imperative to create an integrated training model to ensure that team-based integrated care delivery is a top training priority for all behavioral health and primary care providers, medical schools, community colleges and graduate medical education programs. SIM's close partnership with the Colorado Department of Human Services (CDHS) Office of Behavioral Health (OBH) provides an integral mechanism for addressing many of the priorities identified by the SIM workforce workgroup and the Workforce & Education Cabinet Workgroup.

The SIM office contracted with OBH for several key SIM initiatives related to training an integrated behavioral health workforce. In AY1, OBH developed and disseminated information and resources about pregnancy and substance use for SIM practices. Resources were made available at A Mother's Connection (http://mothersconnection.com). A letter identifying a contact person at OBH for practices to contact for more information was distributed to key stakeholders, health organizations, and professionals in the behavioral health and primary care sectors. In AY4, OBH will continue to share this information as new health organizations and practices are identified.

In AY2 OBH worked with the Office of Children Youth and Family (OCYF) to distribute new 2017 State Guidelines on Psychotropic Medications for Children and Adolescents in Colorado's Child Welfare System. OBH created a video promoting the new guidelines and distributed both to SIM cohorts via SIM staff and all applicable OBH contacts via the OBH list serve. The final report was released in October 2017. The OBH video module was hosted on the new UCDFM eLearning Management System platform in July of 2017.

Throughout AY3 OBH staff met with area leaders of behavioral health clinics, medical primary care practices, government offices, local non-profits such as the Colorado Health Institute, Regional Health Connectors, the University of Denver Graduate School of Social Work faculty, the Colorado Department of Public Health and Environment (CDPHE), the University of Colorado Department of Family Medicine faculty, and other key stakeholders to identify opportunities for collaboration and complementary program development. The intent of these conversations was, and continues to be, increased efficiency, reduced duplication, and strong collaboration in developing relevant and timely educational opportunities that enhance workforce integration. These conversations were essential to fostering positive and effective relationships between OBH and other key leaders in the SIM integration effort, which will continue into AY4. Several key conversations provided greater understanding of where and how OBH will need to provide ongoing support for behavioral health providers as they work to integrate and collaborate with primary medical care providers across the state of Colorado after SIM funding has ended, which will factor into sustainability discussions.

E-learning modules

During AY3, OBH-SIM staff developed five training modules calling for behavioral and medical health providers to work in collaborative integrated professional teams. These modules are available to all SIM cohort practices and all providers working to integrate teams across the state. The SIM office has been able to gauge use through OBH monthly reports which included the user reports generated directly from the eLearning platform https://cuelearning.org. E-learning modules were migrated to a new platform at

the start of AY3 and disseminated to primary care practices. OBH collaborated with UCDFM to host all SIM funded education modules on the same platform to ensure convenient and consistent access for SIM practices. Alignment of provider education opportunities were a key priority for AY3 and will continue to be for AY4. (See the attached *Road Map for Sustaining SIM OBH Investments*).

1. Substance Use Training Unit in three parts. The team decided that the topic of Substance Use Disorders (SUD) as a training module was too broad and the relevant training curriculum content needed to be presented by subtopics. The SUD training module was designed in three separate and complementary segments, each highlighting a key component of topic specific information for both medical and behavioral health integrating team members. The topics are: Introduction to Substance Use Disorders; Screening, Brief Intervention, Referral to Treatment (SBIRT); and Opioid Related Disorders. During August and September 2017, the SIM-funded OBH program staff worked with local content experts to develop training modules now hosted on the University of Colorado Department of Family Medicine's e-Learning platform.
    a. Introduction Part I – this module introduces SIM, discusses transformation and integration policy to provide better understanding of fiscal sustainability, patient access, and provider engagement.
    b. SBIRT Part II – a component to OBH's charge to enhance and expand the work in Colorado to implement SBIRT, a national model for behavioral health screening and referral that increases knowledge regarding behavioral health needs for unique populations. OBH is working to identify barriers to implementation, encourage non-participating sites to implement SBIRT and collaborate with Peer Assistance to develop an online substance use disorder treatment resource directory.
    c. Opioids Part III – an online education module that contains relevant and timely information to behavioral health and medical health providers working in primary care to expand early identification and treatment options for providers, who are challenged with the risks of opioid prescribing and issues related to opioid use disorders.
2. Psychological Trauma & the Integrated Care Team Training Module - an online educational course and course materials using the most appropriate format for trauma and trauma-related issues completed in February 2018.
3. Whole-Person Care for the Aging and Senior Patient Training Module - an online education and training course for senior behavioral health issues that encompasses intervention strategies for integrated care teams. The topic of senior care and the unique needs of our senior population are considerable. The team expects a second module to be completed in AY3 with reserve AY3 funds.

Training Module	Description	Launch Date
STATE GUIDELINES FOR PSYCHOTROPIC MEDICATIONS	"The Psychotropic Medications for Children and Adolescents module introduces the new 2017 Guidelines for children in Colorado's Child Welfare System. Current issues are discussed surrounding the use, maintenance, and monitoring of psychotropic medication as treatment for youth."	February, 2017
SUBSTANCE USE DISORDER MODULE PART I: INTRODUCTION	"The Introduction to Substance Use Disorders module examines the value and importance for medically trained primary care team members to address substance use disorders during a patient encounter and to provide tools to help you move efficiently through this process."	August 2017
SUBSTANCE USE DISORDER MODULE PART II: OPIOIDS	"The Opioids module in the Substance Use Disorders series examines the value and importance of the medically trained primary care team member in prescribing and monitoring opioid use during a patient encounter, and how the primary care team can treat, as well as refer these patients."	September 2017

SUBSTANCE USE DISORDER MODULE PART III: SBIRT	"The SBIRT module in the Substance Use Disorders series examines the tools of the SBIRT process and discusses how the integrated medical team can effectively identify, treat, or refer mild to severe disorders."	October 2017
TRAUMA AND TRAUMA-RELATED ISSUES MODULE	"The Psychological Trauma module explores the effects and range of trauma that a primary care provider may encounter during a patient visit, and how the integrated care team can address this issue to treat the whole patient."	February 2018
SENIOR BEHAVIORAL HEALTH ISSUES MODULE	"The SIM module "Whole-Person Care for the Aging and Senior Patient" identifies Seniors behavioral health issues, such as independent living, transportation, and access to food, for the integrated primary care team."	March 2018

During AY3 several of the data collection points, outlined in the original application and Inter-Agency Agreement (IAA) between OBH and SIM were revised. An IAA #2 was written in which new data collection methods were identified to ensure more accurate and relevant data would be collected. The OBH-SIM data collection points now include key informant reports from providers, who completed at least one of the SUD training modules.

Promote Colorado's behavioral health resources

SIM-funded Office of Behavioral Health (OBH) staff was charged with identifying and promoting behavioral health support and education resources to at least 50 community resource persons. During the past two years, staff have presented or distributed information about current and relevant behavioral health resources to more than 600 resource persons. This includes: regional health connectors, practice facilitators, Project ECHO attendees, Colorado Rural Health Conference attendees, SIM cohort representatives attending Learning Collaborative sessions, the Greater Denver Metro Health Care Partnership, and OBH staff. Beyond those 600, news about the e-Learning modules have been announced in monthly newsletters distributed by OBH, CDHS, SIM, the University of Colorado Department of Family Medicine, and the University of Denver Graduate School of Social work. In November of 2017 the SIM-funded OBH staff began working with Office of Behavioral Health Licensing and Designation Database and Electronic Records System (LADDERS) platform designers to host the full series of Integrated Behavioral Health (IBH) training modules for easy access to all behavioral health providers across the state of Colorado. LADDERS launched in early January and a link to the e-Learning platform is prominently hosted.

Workforce work group subcommittee

This subcommittee, which will continue in AY4, was created to ensure the Certificate/Endorsement was designed to best meet true behavioral health workforce needs related to the process of integrating with medical/primary care providers. Membership was based off discussions with the SIM workforce workgroup co-chairs, key OBH leadership and the SIM office. It now includes a representative of each organization involved in delivering e-Learning and other educational activities. Members represent OBH, the CO Department of Public Health and Environment (CDPHE), University of Denver Graduate School of Social Work, and the University of Colorado's Department of Family Medicine (UCDFM) and Practice Innovation. The subcommittee continued to meet throughout AY3 to inform focused development of the IBH Training Certificate/Endorsement (Bundle) and subsequent certificate of completion, IBH Best Practice Guidelines, the IBH Education Consortium and the IBH Symposium, which will be hosted in AY4.

Certificate/Endorsement, best practice guidelines, IBH Core Competencies

In AY3, OBH worked to develop a voluntary training certification or endorsement that would best meet the needs of current and incoming behavioral health providers working collaboratively with medical care

providers to deliver integrated care in primary care settings to shared patients. Great care was taken to gauge current opinion in the behavioral health workforce as to the current need for a certificate. There was no call from employers for an additional certificate that would increase the value of a current or potential employee. Practicing behavioral health providers did not voice a desire for a new certificate. It became clear that there was no appetite for a new certificate. However, there was a desire for training that would help behavioral health providers better understand the skills necessary to collaboratively provide patient care in the primary medical health setting. To design evidence-based training that met actual workforce needs, a thorough review of current IBH competencies was conducted in the summer of 2016. After careful consideration, the Core Competencies for Behavioral Health Providers Working in Primary Care (CCBHP) (Miller et al., 2016), developed with the leadership of the Eugene S. Farley, Jr. Health Policy Center, were identified as having the most pragmatic competencies. It was from these competencies that the Certificate of Completion was designed to include completion of four courses in which content was aligned with the CCBHP.

The IBH Certificate of Completion aligns with the CCBHP developed collaboratively by the SIM workforce workgroup and other key stakeholders and will drive the development of Best Practice Guidelines to be developed in AY4. The Certificate of Completion was presented at the Integrated Behavioral Health Education Consortium, which was attended by representatives from more than 30 health care organizations, government agencies, individual providers and educators. The four core training modules were developed by a collaboration of UCDFM and the Eugene S. Farley, Jr. Health Policy Center. The core courses will be complemented by two OBH, topic specific modules, of the learner's choice. At the time all six modules are completed a Certificate of Completion will be issued. The bundle of modules required to be issued the Certificate of Completion are:

- Module 1. Introduction to Behavioral Health for Primary Care
- Module 2. Integrated Workflow
- Module 3. Behavioral Health Provider and the Care Team
- Module 4. Patient Engagement and Behavioral Health
- Module 5. Choice of OBH training modules addressing: Substance Use Disorders, SBIRT, Opioids, Psychological Trauma or Seniors
- Module 6. Choice of OBH training modules addressing: Substance Use Disorders, SBIRT, Opioids, Psychological Trauma or Seniors

To ensure the CCBHP are represented fully in curricular content and subsequently acquired by BH provider-learners, competencies will be measured in two ways. First the training modules designed using SIM funding, to deliver training for BH providers and their integrated care teammates, will be assessed using a curricular assessment crosswalk to ensure each CCBHP is fully represented in the training curriculum. This is a critical step in quality assurance for training participants, future integrated teams, practice leadership, and ultimately to the patient. Any areas of the training that do not accurately or fully prepare BH providers for work in the integrated primary care setting will be revised.

Second, at the end of each training module a post-knowledge skills assessment will be completed by each user to confirm individual mastery of the learning outcomes as they relate to each CCBHP. Successful completion of the post-knowledge skills check will result in a module-specific certificate of completion. The BH provider can also use the certificate to apply for continuing medical education (CME) or continuing education unit (CEU). Upon completion of the set of modules necessary to learn all eight competencies and how to pragmatically incorporate the relevant knowledge, skills, and attitudes in collaborative integrated patient care, the BH provider will be issued a program certificate.

Components of the IBH certificate are housed and in use by providers on the University of Colorado Anschutz Medical Campus e-Learning platform (e.g. IBH and transformation training modules). Functionality can and should be expanded to support the full certificate process. Future work is needed and might require additional funding. This final investment will ensure sustainability and ongoing, statewide support for transformation efforts. The e-Learning platform can be developed to maintain learner records and issue the certificate of completion when a learner completes all six modules. The bundle of courses and certificate of completion will be promoted at the 2018 IBH Symposium, which is tentatively planned during AY4. Other more traditional marketing tools will be used such as newsletters, listservs, practice transformation efforts, websites, professional organizations and institutions of higher education.

Best Practice Symposium

With SIM funding, OBH is tasked with convening a best practices symposium in AY4 to share the IBH Best Practice Guidelines and the Certificate of Completion consisting of the bundled training modules. The symposium will be open to all behavioral health providers to promote adoption of best practices for behavioral health staff working in health settings and pursuit of the certificate. Discussions to define the scope of the symposium are underway. The work OBH is embarking on directly correlates with the objectives of the workforce workgroup, which will offer recommendations regarding minimum qualifications, credentialing and training as OBH develops training modules for providers. The workgroup will also offer guidance on the best ways of delivering training to providers. OBH will work to support practices as they integrate behavioral and physical health in primary care settings with training, resource development and sharing, certification and collaboration.

Integrated Behavioral Health - Education Consortium

In AY3 OBH was invited to collaborate with University of Denver Department of Social work in the development and facilitation of the second annual IBH Consortium with SIM funding. The intent of this second Consortium was to gather leaders in physical and behavioral health education from across the state to discuss and collaborate on issues related to transformation of primary care to integrated patient care delivery. The focus of this year's agenda was the movement of the evidence-based IBH Core Competencies to practice patient care and training curricula.

The second annual IBH Consortium was held in February 2017, at the University of Denver's Graduate School of Social Work. Stakeholders from the first annual 2016 Consortium were reconvened, and new leaders included to focus on workforce issues, important educational needs not yet addressed for specific populations, and to consider sustainability of current progress. This unique event facilitated conversations that reflect a broad set of perspectives including: rural and urban constituencies, large and small health systems, private and publicly owned organizations, educators and professionals currently delivering direct patient care, private and public payers and government agencies. The day's agenda included:

- SIM overview and introduction by Barbara Martin;
- Keynote address by Andrew Romanoff, president and chief executive officer of Mental Health Colorado;
- A panel presentation by key leaders of rural community health centers, acute care hospitals and integrated health systems;
- A series of small groups discussions addressing the health and needs of special populations;
- An overview of and introduction to the e-Learning platform and bundle of IBH training culminating in the IBH Certificate of Completion; and
- Discussion around the culture and sustainability of integration efforts across Colorado.

A summary report of the discussions is due to be released by the DU Graduate School of Social Work in May 2018, and the SIM team will discuss ways to use and disseminate the findings in AY4. Additionally, in AY4 OBH will host a symposium at DU.

Innovations and opportunities

The SIM-funded OBH staff has had several opportunities to be involved in additional initiatives related to SIM that were not anticipated, such as discussions regarding additional support for pediatric practices and representing SIM in the role of grant manager for the IT MATTTRs2 program through which prescribing authorities can complete the X-waiver training and their practice can receive coaching to include medication assisted treatment (MAT) to patients who have opioid use disorders. The OBH-SIM program manager was also invited to work with the University of Colorado Cancer Center to build a resource list for integrating primary care teams that are working with patients returning to their practices after cancer treatment. The resource list was shared in an ECHO (Extension for Community Health Outcomes) session, which is a unique platform that provides health professionals and those whose work impacts health the opportunity to be part of a community in which experts and peers share knowledge and experience using technology, not proximity, to connect. Most recently the program manager was invited to participate in the University of Colorado – Colorado Clinical and Translational Sciences Institute (CCTSI), a program funded by the National Institutes of Health that offers entrepreneurial training to select programs that are working to bring innovative programs to health care providers. And lastly, OBH dedicated $10,000 to add a module regarding IBH in Pediatric Care to support the expansion of training topics hosted on the CU e-Learning platform.

Another unexpected opportunity came in the form of working with the Metropolitan State University, Department of Social Work. The department, along with Colorado State University, received funding from Health Resources and Services Administration (HRSA) to provide education to social work students in the field of health care including integration. The SIM office provided perspectives on integration in Colorado and acted as the spotlight agency in a class on social entrepreneurship. Students studied SIM goals, heard from three members of the SIM team and developed a non-profit agency to continue to work of SIM as their final assignment. Once this is received, the SIM team will read and see what suggestions could be adopted for the sustainability plan in AY4.

8. SIM alignment with state and federal initiatives

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:

a. CMCS (waivers, SPAs, etc.)

SIM leverages a strong foundation of federal, state, and private sector investments in primary care transformation and integration. The team builds on these initiatives to consolidate and align statewide efforts to sustain long-term comprehensive health care innovation.

At the highest level, SIM acts as a focal point for aligning the philosophical vision of health care transformation in Colorado. In the State of Health report, Governor Hickenlooper wrote:

> "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."

The SIM office recognizes that no one initiative can achieve the goals of the entire state, but strives to ensure that the initiative is visible, accessible, and influential throughout the state. To maximize its effects, the SIM office (1) Coordinates with and builds upon existing initiatives and (2) Ensures that federal funding will not be used for duplicative activities, or to supplant current federal or state funding.

SIM has partnered with both HCPF and DOI to assess opportunities to align across state and Federal initiatives. Medicaid is required to submit a waiver as part of its Hospital Transformation Program and will consider other components based on the outcome of the 2018 legislative session. SIM meets with HCPF leadership weekly to assure alignment of these efforts.

Information about the advanced APM work is outlined in the "systems delivery and payment models" section.

In AY3, the Division of Insurance explored opportunities to make health care more affordable through a legislative exploration of reinsurance models. Although legislation was not passed this session, DOI remains active in understanding the burden of health care costs to consumers and in AY4 the SIM team will continue to participate in these discussions.

b. CMMI (e.g., CPC+, AHCs, TCPi, ACOs, etc.)

Quality payment program (MACRA)

As detailed in the quality measures alignment section, the SIM initiative streamlined its clinical quality measures (CQMs)to better align with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and other initiatives. The sustainability plan outlines how SIM used its cohort-2 RFA to present SIM participation as an opportunity to prepare for long-term changes in the payment reform landscape. At the September 2016 collaborative learning session Pam Ballou-Nelson, RN, MA, MSPH, PhD, PCMH CCE, principal consultant with the Medical Group Management Association (MGMA) gave a presentation entitled "Understanding and Executing the MIPS Four Domains: How do they apply to my practice," in which she discussed alignment between work with SIM and preparation for the Quality Payment Program (QPP). CQM feedback reports delivered to each practice, comparing their own progress on CQMs with that of the whole cohort's progress, include QPP benchmarks to assist practice's preparations for QPP performance reporting. The SIM office and the University of Colorado Department of Family Medicine (UCDFM), a practice transformation partner, will continue to keep QPP and MACRA as a training topic at future collaborative learning sessions.

SIM's HIT section outlines the steps that the state is taking to support practices as they prepare to report CQMs for programs, such as QPP. The SIM office's HIT investments are focused on practice-level data extraction, validation and reporting. We continue to hear concerns from providers about data accuracy and questions about whether the data is actionable and represents the quality of care delivered. Education and practice coaching will continue to focus on this in AY4 with additional coaching provided to cohort-1 practices that opt-in to using clinical health information technology advisors beyond their two-year agreement with SIM.

Colorado QPP coalition

The SIM team was a founding member of the Colorado QPP coalition (CQPPC), which comprises health care leaders in the state, and helps create and disseminate education and tools to help providers prepare

for and succeed in the QPP. In AY4, the team will continue to participate in monthly meetings, help design and give presentations to provider audiences, and share CQPPC materials through SIM publication channels. Learn more about the coalition: http://www.cms.org/communications/colorado-qpp-coalition.

The CQPPC[17] started with 14-member organizations and is dedicated to (1) Increasing QPP awareness among Colorado health care providers using common messaging, (2) organizing education efforts, and (3) coordinating effective and efficient technical assistance for physician practices. The CQPPC began providing training in January of 2017 and intends to continue at least through the end of 2018.

In AY4, the SIM team will continue to play a leadership role in the CQPPC and create messaging and education for member organizations to disseminate to their stakeholders throughout Colorado.

Comprehensive Primary Care Initiative (CPCi)

Colorado was one of seven markets selected by CMS to participate in CPCi, a multi-payer initiative designed to test practice redesign models and a supportive multi-payer payment model from 2012 to 2016. In many ways, CPCi served as a foundation for SIM, which built off its work in the following ways:

- Multi-Payer Collaborative (MPC): Public and private payers came together under CPCi, which led to creation of the MPC, a self-funded, self-governing entity formed by payers to develop organizational alignment and consistency around the support of CPCi practices. Payers elected to continue using the MPC as a primary forum to develop support for SIM and continue to use Oregon Health & Science University as a facilitator (see the payment and service delivery models section for more information). Building upon the MPC's foundational work under CPCi, SIM continued to 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 for SIM will advance through components of the payment models established under CPCi, which will improve likelihood of receiving enhanced funding from public and private payers. We also expect that participation in CPCi, SIM, or both will increase practices' capacity to serve larger groups of patients more effectively and efficiently, which will contribute to sustainability. SIM initially used the basic CPCi measure set as a foundation for its CQMs.
- Data aggregation: SIM's HIT plan builds on the Stratus™ tool developed by payers that participated in CPCi. SIM extended Stratus™ licenses to cohort-1 practices and is rolling out access to Stratus™ for cohort 2 and eventually cohort 3. The HIT section includes information about how Stratus™ has informed the initiative's HIT strategy.
- Practice transformation: The SIM office and payers recruited CPCi practices to join SIM. In total, 32 of the first 100 practices to participate in SIM participated in CPCi. The SIM office adopted 10 practice transformation building blocks to align with the CPCi milestones. These milestones have since been revised for cohorts 2 and 3 to better align with payer priorities and reflect SIM's focus on behavioral health information, but they were designed based on CPCi milestones. See the payment and service delivery models section for more information about the building blocks.

Comprehensive Primary Care Plus Initiative (CPC+)

SIM recognizes that aligning with and complementing the work of CPC+ is critical to the success of both initiatives. As discussed in the Health care Delivery Transformation section of the plan, the SIM office decided to delay the start of cohort 2 to allow sufficient time to outline a plan for how the initiatives would work together and give practices an opportunity to learn if they were participating in CPC+ before applying to SIM. Sixty two of the 226 applications for SIM cohort 2 and 18 of the 90 applicants for cohort 3 are

[17] http://www.cms.org/coqpp

enrolled in CPC+.

Before releasing the request for applications (RFA) for cohort 2, the SIM office submitted a proposal to CMMI entitled “Colorado State Innovation Model (SIM) Proposed Alignment with the Comprehensive Primary Care Plus (CPC+) Initiative,” which was reviewed by the CPC+ team and approved by Joshua Traylor, SIM’s project officer at the time. The proposal outlined a comprehensive plan for alignment with CPC+ and is included as ***Appendix K1***. Furthermore, the RFA for cohort 2 provided information about what participation in both initiatives would mean for practices. A table summarizing the information is included below with additional information in the Health care Delivery Transformation section of the plan.

In AY4, the SIM office will continue to work closely with the CPC+ team to refine alignment between the two initiatives. In April 2017, the two teams had an initial phone call to discuss alignment and decided to continue meeting quarterly by phone to discuss questions as they arise. The SIM office will seek ways in which training and resources can be shared among participants in both initiatives.

<table>
<tr><th colspan="2">SUMMARY OF SIM PARTICIPATION EXPECTATIONS</th></tr>
<tr><th colspan="2">Shared Expectations of All SIM Practice Sites</th></tr>
<tr><td colspan="2">1) Identify a cross-functional quality improvement team to implement improvements based on the SIM Practice Transformation Building Blocks.

2) Complete a set of practice assessments to identify key areas of focus for improvement.

3) Participate in SIM evaluation activities.</td></tr>
<tr><th>Expectations of practice sites in SIM-Only</th><th>Expectations of practice sites in CPC+ and SIM</th></tr>
<tr><td>4) Required to attend the SIM CLS events.

5) Collect, report, and review SIM Clinical Quality Measures on a quarterly basis.

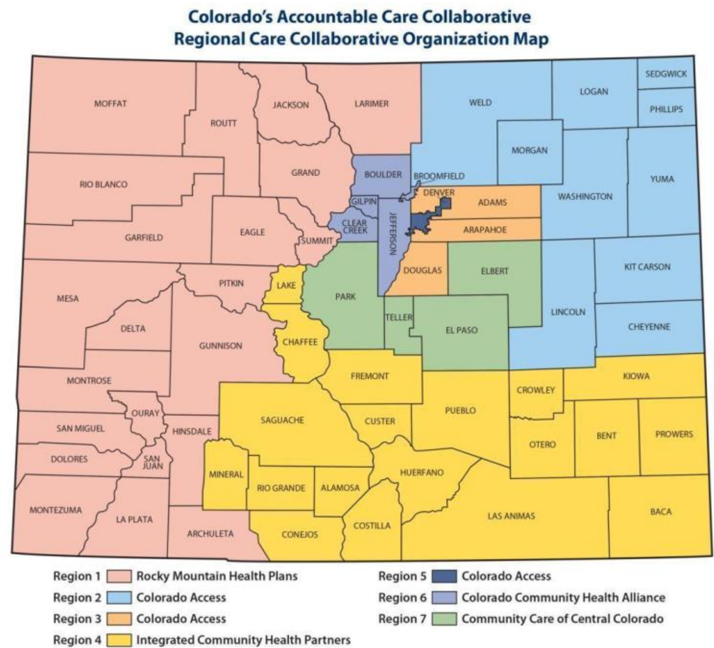
6) Complete a foundational subset of building blocks through achievement of key milestones.</td><td>4) Encouraged to attend the SIM CLS but not required to do so.
5) Collect, report, and review only the SIM Clinical Quality Measures that align with CPC+ requirements on a quarterly basis.

6) Complete an advanced subset of building blocks through achievement of key milestones.

** Practice sites in CPC+ and SIM will be expected to adhere to all expectations of CPC+</td></tr>
</table>

Medicaid-led transformation efforts

The Department of Health Care Policy and Financing (HCPF) is committed to creating a high-performing, cost-effective Medicaid system that delivers quality services and improves the health of Coloradans. The Accountable Care Collaborative (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. Phase II of the ACC seeks to leverage the proven successes of Colorado Medicaid's programs to enhance the Health First Colorado (Colorado's Medicaid program) member and provider experience. In ACC Phase II, both physical and behavioral health will be under the regional accountable entities (RAEs). The following section outlines current and upcoming iterations of the ACC and how SIM has aligned with both interactions.



Accountable Care Collaborative (ACC)

The ACC is the primary care delivery system for Health First Colorado. ACC clients have access to medical homes that provide primary care, preventive services, specialist referrals, and health education. Primary care medical providers (PCMPs) are considered a client's medical home.
Starting on July 1, 2014, HCPF took steps to recognize and reimburse PCMPs who offer services beyond the traditional fee-for-service (FFS) primary care service delivery model through the enhanced PCMP (EPCMP) program. EPCMPs can earn an additional $0.50 per member per month (PMPM) by meeting at least five of nine enhanced primary medical home factors. The nine factors are based on the medical home standards from National Committee on Quality Assurance (NCQA), recommendations from the regional care collaborative organizations (RCCOs), Colorado Senate Bill 07-130, which defined the criteria for medical homes for children and other key HCPF initiatives designed to incentivize quality improvement.[18] These factors closely align with SIM milestones, and two (bolded in footnote[1]) directly relate to integrating behavioral health. The state is divided into seven RCCOs (see map inset) that help develop a network of providers, support providers with coaching and information, manage and coordinate member care, connect members with non-medical services, and report on the costs, utilization, and outcomes for their client populations. ACC clients are attributed to a RCCO based on the county in which they live. RCCOs help ACC clients find a PCMP and access appropriate services.

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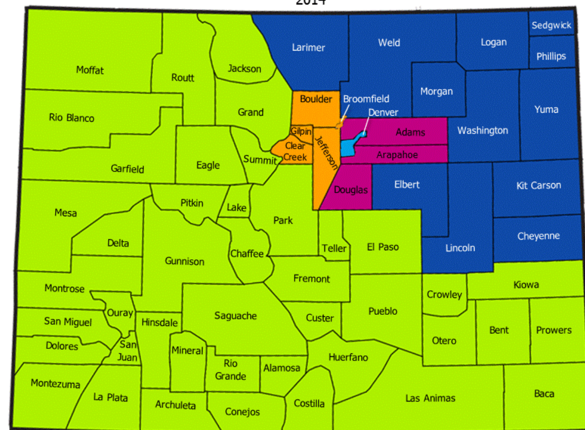
[18] The nine factors are: Extended Hours, Timely Clinical Advice, Data Use and Population Health, **Behavioral Health Integration**, **Behavioral Health Screening**, Patient Registry, Specialty Care Follow-Up, Consistent Medicaid Provider, and Patient-Centered Care Plans

Behavioral health organizations (BHOs)

There are five BHOs in Colorado (see map inset) that align efforts with physical health providers in preparation of ACC Phase II. For example, they are working to evaluate the behavioral health needs of PCMPs clients 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 use disorder services with PCMPs.



ACC phase II:

The next phase will further advance the ACC's proven success as a vehicle for Medicaid reform innovations that incentivize care coordination and the wise use of health services. Combining administration of physical health and behavioral health under one regional entity (the regional accountable entity or RAE) will establish a cohesive network of physical and behavioral health providers, who can more effectively coordinate health care services for clients across disparate providers including long-term services and supports (LTSS), specialty care, oral health and social agencies. For a map of the new RAE regions, please see appendix (*labeled* ***Appendix K2*** *state alignment section RAE map*)
HCPF issued a request for proposals (RFP) for RAE contractors in May 2017, following a draft RFP public comment period in fall 2016-winter 2017. Contract awards for the seven regional RAEs were announced, and contracts are being executed in 2018. During the spring 2018 start-up period, RAEs will establish their provider networks, finalize policies and procedures, and review their technology systems to ensure a seamless delivery of services to clients on July 1, 2018. During the start-up period, the RAEs will establish their provider networks, policies and procedures, and technology systems to ensure the seamless delivery of services to clients. A Health Services Advisory Group is also performing a readiness review of each RAE in compliance with federal regulations to ensure the new vendors are fully ready to begin operations.

SIM Alignment:
HCPF also serves as a payer supporting Health First Colorado practices participating in SIM. This payer support in AY3 was executed through the RCCOs. The SIM office coordinates with RCCO representatives regarding delivery of payment support to SIM practices and will coordinate with the RAE representatives through the transition in AY4. Recognizing the RAEs will be the primary point of contact for many SIM practices, the SIM office will provide RAEs with standardized training about the SIM initiative. The SIM office will provide stock language for communications from RAEs to SIM practices to ensure message consistency. RAE representatives will also participate in quarterly Multi Stakeholder Symposiums (outlined in the Stakeholder Engagement section of the plan).

ACC participation in SIM has been described by HCPF leaders as a "central component of the department's behavioral and physical health integration strategy." The RCCOs/RAEs make incentive payments to selected PCMPs who participate in SIM to help them integrate physical and behavioral health care and progress through the milestones. HCPF provides financial and administrative oversight for SIM, and has key staff in each of the seven SIM workgroups to ensure continuity of support and to facilitate alignment and

synergy with the ACC.

From February 2016 through February 2018, HCPF supported SIM's goal of recruiting primary care practices and helping them transition to care delivery models that integrate physical and behavioral health care.

Through the involvement of ACC primary care practices, HCPF receives benefits of SIM practice transformation that include SIM-funded education for providers that supports practice integration and transformation, and connection between communities and practices. HPCF leaders say, "These and other aspects of our participation in SIM are helping us prepare providers to integrate physical and behavioral health in FY 2018-19 when the new ACC contract begins (ACC Phase II)."

HCPF APM

HCPF, in collaboration with community stakeholders, developed a new Alternative Payment Model for Primary Care (APM), which has the following goals:

- Provide long-term, sustainable investments into primary care;
- Reward performance and introduce accountability for outcomes and access to care while granting flexibility of choice to Primary Care Medical Providers (PCMP), and;
- Align with other payment reforms across the delivery system.[19]

Members of the SIM team attend weekly APM meetings hosted by HCPF to ensure continued alignment. HCPF has engaged with SIM and the MPC to support and expand primary care transitions across the state and engaged with commercial payers and SIM to seek alignment on APM measures. Practices participating in a SIM cohort will automatically be eligible to participate in the HCPF APM and will receive full credit for the first year of the APM. In AY4, the SIM team will continue to work with HCPF to communicate this benefit.

Medicaid Innovation Accelerator Program: Reducing substance use disorders

The Medicaid Innovation Accelerator Program (IAP) is a support program out of CMS to help states improve the health and health care of Medicaid beneficiaries and to reduce costs by supporting states' ongoing payment and delivery system reforms. Medicaid IAP supports state Medicaid agencies to build capacity in key program and functional areas by offering targeted technical support, tool development and cross-state learning opportunities. HCPF was recently notified of its successful application to be one of up to 12 states to receive this support. The goals of Colorado SIM align closely with the IAP focused program area of reducing substance use disorders and supporting physical and mental health integration. HCPF intends to work closely with the Office of Behavioral Health (OBH) and Department of Public Health and Environment (CDPHE) to align efforts and ensure the most powerful impact. Key focus areas of Colorado's IAP implementation will be early identification of substance use disorders to access earlier treatment and reduce emergency department visits, as well as focusing on Colorado's maternal population, with drug use being the second leading cause of non-pregnancy related death. Colorado's goal is to determine:

- What do the existing data sources illustrate about the incidence and prevalence of opioid use disorders (OUDs) so we can better leverage existing pathways to care?

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[19] The Colorado Department of Health Care Policy and Financing. "Primary Care Alternative Payment Model Survival Guide."
https://www.colorado.gov/pacific/sites/default/files/Alternative%20Payment%20Model%20Survival%20Guide%2011.7.17.pdf

- Which data are missing from our current resources, so we can build a more robust infrastructure to complete the OUD picture in Colorado?

Colorado Medicare-Medicaid program: Duals integration

In June 2014, HCPF received a $13.6 million grant from CMS to implement a three-year 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. Health First Colorado clients who are eligible for Medicare and Medicaid comprise approximately 7% of the department's Medicaid enrollment, but accounted for 29% of the state's costs.[20] More than 50% of Medicare-Medicaid beneficiaries are older than 65, and more than 605 of them have multiple, chronic health conditions.[21]

HCPF 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 evolved, it provided HCPF and other state agencies and organizations with valuable feedback regarding best ways to achieve person- and family-centered care and placing clients or patients at the center of their care planning and delivery.

The term of the demonstration ended on Dec. 31, 2017, and members of the Medicare-Medicaid program have been transitioned back into the ACC. Preliminary report: www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/COEvalMedicareCostYr1FinalReport082817.pdf.

Medicare advanced primary care

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

Medicare shared savings programs

The following accountable care organizations (ACOs) are participating in the Medicare Shared Savings Program and include Colorado in their service areas:

Name	ACO Agreement	Track
Physician Health Partners, LLC	Renewal	1
Community Health Provider Alliance	Initial	1
San Juan Accountable Care Organization, LLC	Initial	1
Rocky Mountain Accountable Care Organization, LLC	Initial	1
UCHealth Integrated Network	Initial	3
Banner Network Colorado, LLC	Initial	2
Clinical Partners of Colorado Springs, LLC	Renewal	1
Colorado Accountable Care, LLC	Renewal	1
Physicians Accountable Care Solutions	Initial	1
Mountain Prairie ACO	Initial	1

ACO Investment Model

The following Colorado ACOs are also participating in the ACO investment model:

[20] HCPF press release

[21] ibid

- San Juan Accountable Care Organization, LLC Grand Junction, CO
- Rocky Mountain Accountable Care Organization, LLC Grand Junction, CO

Practices within these organizations are eligible and encouraged to apply for SIM.

Pioneer/NextGen ACO Model

No ACOs in Colorado participate in CMMI's Pioneer or NextGen ACO Models.

Health care innovation awards

These eight projects 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 and 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 Health care 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 Interventions to Reduce Acute Care Transfers (INTERACT), an evidenced-based assessment tool 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 to reduce costs and to improve the quality of care in rural and remote areas of southwestern Colorado.

National Association of Children's Hospitals and Related Institutions

Project Title: "Coordinating All Resources Effectively (CARE) for Children with Medical Complexity"
Description: The National Association of Children's Hospitals and Related Institutions is testing CARE for children with medical complexity (CMC), which aims to inform sustainable change in health care delivery through new payment models that support improved care and reduced costs for CMC.

All projects align with SIM's vision and goals. However, no direct collaboration has occurred to date and the three-year initiatives have all ended.

Bundled Payments for Care Improvement Initiative (BPCI):

13 sites in Colorado are participating in CMMI's BPCI Model 2 and Model 3 demonstrations, including: hospitals; orthopedic practices; skilled nursing facilities; and home health care agencies.

Organizations Participating in BPCI	Model	# of Episodes
Colorado Springs Orthopaedic Group, Colorado Springs, CO	2	1
Orthopaedic & Spine Center of The Rockies, A Professional Corporation, Fort Collins, CO	2	2
Panorama Orthopedics and Spine Center Pc, Golden, CO	2	1
Brighton Operations, LLC, Brighton, CO	3	21
Emeritus at Green Mountain Long Term Care Community, Lakewood, CO	3	24
Emeritus at Roslyn Long Term Care Community, Denver, CO	3	1
Encompass Home Health of Colorado, Colorado Springs, CO	3	1
Encompass Home Health of Colorado, Denver, CO	3	6
Encompass Home Health of Colorado, Fort Collins, CO	3	6
Glenwood Investments & Associates, LLC, Glenwood Springs, CO	3	6
Northglenn Operations, LLC, Northglenn, CO	3	17
Paonia Investments & Associates, LLC, Paonia, CO	3	8
Rocky Ford Health care, LLC, Rocky Ford, CO	3	26

BCPI Advanced

The team is aware of the BCPI Advanced Initiative, which will start Oct. 1, 2018. Participants have not yet been selected but we will continue to monitor the initiative in Colorado.

SIM anticipates that bundled payments will continue to be included as a component of alternative payment models (APMs) and will align with and incorporate best practices from past and ongoing bundled payment initiatives in the state. SIM's bidirectional pilot project, administered through the Colorado Behavioral Health Council (CBHC) will explore the use of performance-based incentive payments, braided funding, and bundled, risk-adjusted payment mechanisms within CMHCs. (Please see the payment and service delivery models section) Health First Colorado might also include bundled payments as part of its reimbursement structure the phase II of the ACC. Bundled payments, particularly as developed and used 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.

Comprehensive Care for Joint Replacement Model (CJR):

Two Colorado metropolitan statistical areas are implementing the CRJ model in Colorado:

- Boulder MSA – including Boulder county
- Denver-Aurora-Lakewood MSA – including Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson and Park Counties.

The University of Colorado Hospital (UCH), one of 22 hospitals in the Denver-Boulder metro area that is participating in CJR has built on its work around bundled payments to create new care delivery strategies, such as the development of "care pathways" that standardize the services patients receive based on evidence and experience. In addition, UCH is piloting an Enhanced Recovery After Surgery (ERAS) program to improve outcomes and reduce hospital readmissions and costs. This program was developed in partnership with the Institute for Health care Quality, Safety, and Efficiency (IHQSE), UCH, Children's Hospital Colorado, and the US School of Medicine and College of Nursing and started enrolling pancreatic cancer patients in April 2017. Colorado's state level bundled payment initiatives include:

- PROMETHEUS - a bundled payment pilots for chronic conditions with self-insured employers in Alamosa, Colorado Springs, and Boulder, sponsored by Colorado's employer purchasing coalition, the Colorado Business Group on Health
- Center for Improving Value in Health Care (CIVHC) - As Colorado's Regional Health Improvement Collaborative, CIVHC is developing bundled payments for acute care episodes with physician groups and hospitals in metro Denver.
- Colorado Public Employees Retirement Association (PERA) - PERA offers 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.

The Colorado Commission on Affordable Health Care:

This commission was created through bipartisan legislation in 2014 and conducted an analysis of health care cost drivers in the state to identify policy priorities and recommendations for the legislature and governor. In the "2016 Report to the Colorado General Assembly and Colorado Governor," the commission recommended a pilot, using state employees, to further test the effect that bundled payments and value-based purchasing might have on employer health care costs. The commission submitted a final report in late 2017:
www.colorado.gov/pacific/sites/default/files/Cost%20Commission%20November%202017%20report%20v3%20draft_1.pdf.

Accountable health communities

There are two Accountable Health Communities (AHC) in Colorado: Rocky Mountain Health Plans (RMHP) serving the western slope, and the Denver Regional Council of Governments (DRCOG) in the Denver region.

RMHP

In April 2017, the community received a $4.5 million grant from CMS for its AHC efforts.
RMHP has committed AHC funds towards:

- Administering a social needs screening beginning in 2018 for most Medicare and Medicaid enrollees;
- Enabling practices to access to a community resource inventory for referrals;
- Providing access to patients with high needs (who have had more than two emergency room visits in the last year) to community-based navigation support;
- Coordinating and collaborating with community-based organizations to provide services;
- Tracking data in a CMS-compliant way to prove program effectiveness; and
- Provide opportunities for community-based organizations to participate in the advisory committee to identify gaps in services and plan and prioritize a strategy to address those gaps.

More information: www.rmhpcommunity.org/ahcm/accountable-health-communities-model.
RMHP is a payer that participates in SIM, a practice transformation organization (PTO) that provides support to SIM practices and a sponsor of the Collaborative Learning Sessions held on the western slope and is close and frequent communication with the SIM office.

DRCOG

This is a planning organization in which local governments[22] collaborate to establish guidelines, set policy and allocate funding in the areas of:

- Transportation and personal mobility
- Growth and development
- Aging and disability resources

DRCOG was awarded a $4.5 million AHC grant from CMS in April 2017 to bridge the gap between clinical and community service providers. DRCOG will serve as a hub for 16 regional partners addressing health-related social needs including housing instability, food insecurity, domestic violence, and transportation.

By addressing these social needs, the model aims to reduce unnecessary health care use and spending by improving health outcomes and quality of care for patients. DRCOG will also coordinate and monitor providers to ensure responsiveness. During the five-year period, clinical and community partners will report on services provided and patient outcomes helping inform best practices for the industry.
More information: https://www.drcog.org/sites/drcog/files/resources/2017DRCOG_CMS.pdf.

Potential opportunities for alignment and collaboration

The SIM office and RHC program staff have met with key leaders from RMHP and DRCOG to operationalize potential avenues for alignment. Due to differences between the two AHC initiatives in Colorado, the RHC program is more engaged with the initiative led by RMHP on the western slope. RMHP has convened a large group of stakeholders to collaborate on the initiative and RHC host organizations will play a key role in the collaboration. In comparison, the initiative led by DRCOG in the metro Denver area will have a more limited scope in terms of community engagement and the number of partners involved. DRCOG is relying heavily on existing capabilities and staff within their organization with plans to expand only when a need is demonstrated through rapid cycle evaluation. The SIM office and RHC program staff are pursuing the following strategies with both initiatives:

[22] https://www.drcog.org/about-drcog/member-governments

- Regional health connectors (RHCs) will share priorities with AHC initiative leaders to avoid duplication of efforts and use resources to achieve complementary goals. On the western slope, five organizations will serve as both RHC host organizations and ACH community leads, which will promote collaboration.
- RHCs will connect SIM practices with key resources developed by or for an AHC initiative, such as the community resource inventory for referrals. On the western slope, RHC host organizations will play a key role in the development and rollout of the community resource inventory.
- The RHC program co-director overseeing SIM funding for the program serves on the SIM population health workgroup and the ACH advisory board on the western slope to ensure coordination with RHC activities.

The SIM office is also pursuing additional avenues for alignment, including:

- Avenues by which SIM-funded local public health agencies and behavioral health transformation collaboratives might engage in AHC efforts.
- Ways in which ACH efforts might help practices achieve practice transformation building block 7: Practice has linked primary care to behavioral health and social services. Year 2 milestones for this building block include:
    - 50% of patients are screened for behavioral health condition(s);
    - Practice performs an assessment of community resources to assist patients/families with social needs (such as food, housing, transportation); and
    - 50% of patients identified with a behavioral health need are connected with resources. ACH efforts might be particularly useful to help practices achieve these milestones.

Transforming Clinical Practice Initiative (TCPi)

The Colorado Practice Transformation Network offers tools and resources for up to 2,000 Colorado providers to be successful in value-based payments. As of April 2018, there are 1,926 providers involved in TCPi. (For more information visit: https://www.colorado.gov/pacific/healthinnovation/tcpi

Alignment of oversight

TCPi is part of the SIM office and the SIM director oversees both initiatives. TCPi staff participate in regular SIM office staff and management meetings. This structure encourages close coordination while helping ensure that efforts are not duplicated. TCPi is also supported by the Colorado Health Extension System (CHES). Many of the practice transformation organizations (PTOs) support SIM and TCPi. CHES provides a central structure to ensure that PTOs align, but do not duplicate, efforts. More information on CHES: www.ucdenver.edu/academics/colleges/medicalschool/departments/familymed/research/practice_transformation/Pages/practice_transformation.aspx.

The SIM team believes TCPi is complementary to SIM yet there are important differences in terms of implementation to avoid duplication of funds used by PTOs that are working with dual SIM-TCPi practices. During AY3, the team made a recommendation to CMMI, which was approved, that practices should be allowed to participate in both initiatives and that dual participation practices are eligible to receive all achievement-based payments through SIM and will only receive cost and utilization survey completion achievement-based payments through TCPi. The rationale is explained below:

While goals for SIM and TCPi are similar — to improve the quality of health care delivery and reduce total cost of care — the initiatives have different interventions. Practice facilitators (PFs) and clinical health information technology advisors (CHITAs) work with practices to achieve milestones (SIM) and aims (TCPi) with deliverables demonstrating progress for each one. The two programs complement and enhance each

other.

Goals:
SIM helps practices integrate behavioral and physical health in primary care settings using a foundation of advanced primary care defined by a slightly modified version of the Bodenheimer Building Blocks of High Performing Practices, and to help practices succeed in alternative payment models.

TCPi has five aims that guide the work of practice transformation organizations (PTOs). The TCPi change package was developed to guide PTO work and support practices to:
1. Improve health outcomes
2. Reduce unnecessary hospitalizations
3. Generate cost savings for the health system
4. Reduce unnecessary tests and procedures
5. Prepare practices to participate in alternative payment models

Behavioral health integration is not mentioned in any of the primary or secondary drivers of the TCPi change package. SIM helps practices manage total cost of care, which includes reducing hospitalizations by ensuring preventive approaches. In comparison, TCPi focuses on helping providers reduce duplicative or unnecessary testing and procedures to reduce their total cost of care, in addition to reducing hospitalizations and emergency department visits.

Some core competencies are present in both initiatives, including team-based care, using data for improvement and engaged leadership, but the context in which they are developed and how they evolve are shaped by the aims of each program and the differences are illustrated in the required documentation.

Each initiative is supported by a different change package. SIM uses the Bodenheimer Building Blocks and TCPi has a unique change package based on three primary drivers, 15 secondary drivers and 26 change concepts. The TCPi primary drivers are:
• Patient and family engagement
• Continuous data driven quality improvement
• Sustainable business operations

Behavioral health integration is not mentioned in the TCPi change package, yet it is the primary goal of SIM to help practices succeed in alternative payment models.

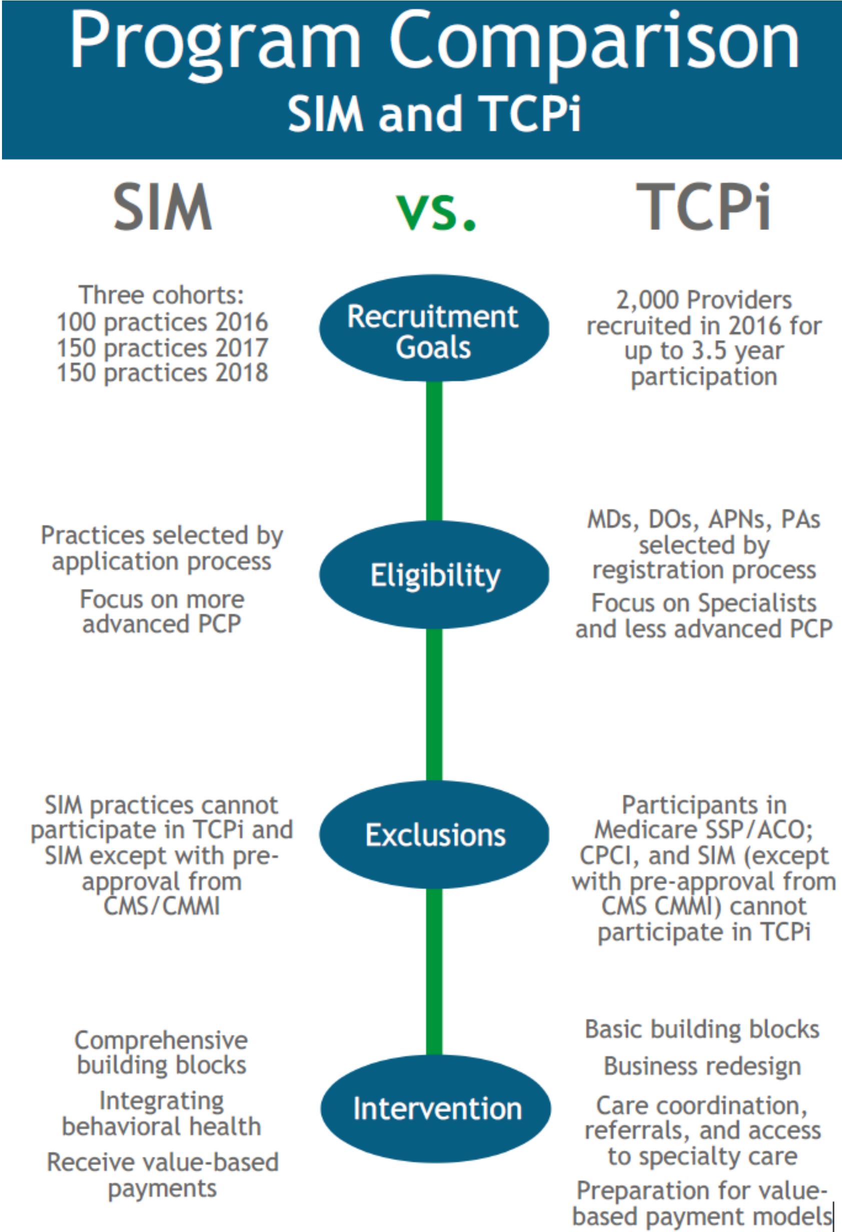
The assessments and documentation for each initiative are different, and the curriculum and guidance for PFs is different though there are essential competencies that are similar.

In TCPi, the practice improvement plan is required twice a year and must include SMART goals that improve specific health outcomes and reduce cost and utilization. The work of the practice is guided by individual goals that are established by a practice based on its priorities.

In contrast, all SIM practices are working on behavioral health integration with designated activities in each of the Bodenheimer Building blocks that are captured in the Milestone Attestation Checklist, which correlates with achievement-based payments and are central to determining what areas a practice will address.

Programmatic alignment

The TCPi application narrative was designed to align with, not duplicate SIM efforts. TCPi complements other statewide initiatives that address how health care is delivered and reimbursed. A substantial part of the work will involve supporting practices as they change operations to optimize care teams and use data effectively to deliver higher-quality, lower cost care. TCPi has aligned its set of primary care focused clinical quality measures to better align with SIM, as well as the Quality Payment Program. However, while SIM is focused on primary care, 90% of participating TCPi providers are specialists. Staff ensures that funds are not supplanted and that efforts are not duplicated in any practice. The graphic below compares the two initiatives and demonstrate how the opportunities build a comprehensive and person-centered statewide system that addresses a broad range of health needs.



Meaningful use and HIT for economic and clinical health (HITECH)

The HITECH Act outlines the plans for adoption of electronic health records (EHRs) through meaningful use

of HIT. CMS Medicare and Medicaid EHR incentive programs support state efforts through three stages of meaningful use, which requires providers to show how they are using their certified-EHR technology to measure quality and quantity. As Colorado evolves from meaningful use to MACRA, practices and hospitals need to have certified 2015 EHRs to extract and report clinical quality metrics automatically from their EHRs. Colorado SIM HIT work is largely focused on understanding, supporting, and advancing practices toward achieving this goal as well as working to align quality outcomes across the state with a better understanding of EHR contracts and operability.
HCPF recognizes the importance of expanding HIT across the state to enhance interoperability and improve care coordination, which will significantly reduce health care costs and improve patient outcomes. With the passage of the HITECH Act in 2009, HCPF could be supported by 90% federal financial participation to help providers become meaningful users of EHRs.

The health information exchange (HIE) network continues to prove its success with the provider onboarding program expanding outreach efforts and technical services to Medicaid eligible providers, who were ineligible for the Office of the National Coordinator regional extension center program. This will continue to boost meaningful use numbers and milestones in Colorado to enhance the HIT vision. In addition to Adopt Implement Upgrade path and the Meaningful Use (MU) education and technical services, the program will continue to assist providers in meeting MU Stage 2 and Stage 3 through onboarding provider interfaces and providing the capabilities to automatically meet several MU measures.

c. CDC, ONC, HRSA, etc.

CDC

The plan for improving population health section outlines the SIM approach to population health. It is partially informed by Colorado's 10 Winnable Battles, which was developed by the Colorado Department of Public Health and Environment (CDPHE) and aligns with several CDC Winnable Battles. Two of Colorado's Winnable Battles are mental health and substance use disorders, and injury prevention; these priority areas are the focus of the population health activities funded by SIM.

ONC

A central component of the Colorado initiative is the expansion of the state's health information technology (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 a statewide reach, public and private collaboration will be essential to achieving the goal. This work could not be accomplished without close alignment and coordination to leverage existing and available resources. The Office of eHealth Innovation (OeHi), the SIM office, and the HCPF Health Information Office (HIO) meet weekly to coordinate project plans and leverage opportunities to complement funding for shared HIT objectives.

OeHi, like the SIM office, is housed within the governor's office to ensure close partnership with coordinated leadership. OeHi plays an important role in strengthening public-private collaboration around HIT initiatives within the state. OeHI is tasked with promoting and advancing the secure efficient and effective use of HIT and coordinating "relevant public and private stakeholders and HIT programs across state agencies and between state and federal projects."[23] The Office, advised by the eHealth Commission, is Colorado's state designated entity for the advancement and implementation of the American Recovery and Reinvestment Act (ARRA) Health Information Technology (HITECH) federal funds.

[23] Executive Order B 2015-008

The Colorado Department of Health Care Policy and Financing (HCPF), is the fiscal agent for this office. Public and private collaboration and coordination will figure prominently in several SIM HIT initiatives and is detailed in the HIT section. The following is a summary of coordinated efforts: OeHI, in partnership with SIM and HCPF has prioritized several key initiatives, which are reflected in Colorado's Health IT Roadmap. This three- to five-year strategic plan leverages crucial work established through SIM, TCPi, and other transformative efforts. OeHI is requesting state funds for federal match of several of these initiatives.

Implementation Advanced Planning Documents (IAPD) are being updated and submitted to CMS for approval of federal matching. This funding will cover provider onboarding, strategic development and implementation of core infrastructure and technical solutions as mentioned in Colorado's Health IT Roadmap to create and enhance sustainable solutions for Medicaid providers serving clients and supporting Medicaid-eligible professionals' (EPs) and eligible hospitals' (EH) achievement of Meaningful Use (MU).

Work completed in AY3 will help establish a sustainability plan for this week. For example, HCPF is submitting the annual IAPD-Update (IAPD-U), which aligns the department's strategy for advancing HIT and health information exchange in Colorado by supporting the design, development, testing and implementation of core infrastructure and technical solutions promoting HIE for EPs and EHs aligned with Colorado's Medicaid Electronic Health Record (EHR) Incentive Program authorized by the American Recovery and Reinvestment Act of 2009 (ARRA). Colorado's health information exchanges (HIES) are essential components of Colorado's HIT ecosystem and continue to evolve.

HCPF also received the Colorado Advanced Interoperability Initiative (CAII) grant from ONC in 2015. CORHIO and Quality Health Network (QHN), Colorado's two HIE organizations, were selected to provide HIE services for the program. The overall goal of the program aimed to generate smoother transitions between care settings by facilitating the seamless exchange of health information between ambulatory providers, behavioral health, and long-term and post-acute care organizations. Because of this program, 470 ambulatory providers are sending care summaries into the CORHIO Community Health Record called PatientCare 360. This includes 31 long-term and post-acute care organizations and two behavioral health facilities. The CAII has enabled CORHIO to increase the amount of clinical data from providers in the HIE. The format of the care summaries sent to CORHIO is Continuity of Care Documents (CCD). These comprehensive documents are generated from the practices' EHR systems and can include vital patient health history, medication lists, recent procedures and problems, lab results and advance directives. This data enriches community health records for patients, enabling their providers to see a more complete picture of medical history and recent encounters, regardless of which EHR systems are used by collaborating providers.

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 SAMHSA in conjunction with CMS and the Assistant Secretary of Planning and Evaluation (ASPE). HCPF used the funds to develop a process for certifying community mental health centers (CMHCs), soliciting input from stakeholders, establishing prospective payment systems for demonstration reimbursable services and preparing an application to participate in the demonstration program. This has informed the process of aligning CMHCs with HCPF needs, especially as the ACC 2.0 is finalizing and determining Regional Accountable Entity statements of work. Although the state did not participate in the full demonstration program, the stakeholder work and engagement in discussion around payment systems is in full alignment with SIM efforts. Colorado did not participate because a majority of prospective partners determined that the certification requirements were too onerous and did not align

with their business development, and Colorado's hybrid payment model proposal did not align with SAMHSA's timing; remaining funds were distributed to CMHCs to help them in their determinations, with the unused portion reverting to SAMHSA.

Health Resources and Services Administration (HRSA):

The SIM office provided a letter of support for the University of Denver (DU) School of Social Work's application to the Behavioral Health Workforce Education and Training Program funding opportunity, which aims to expand the mental health and substance use (jointly referred to as behavioral health throughout the funding opportunity announcement) workforce serving children, adolescents and transitional-age youth at risk for developing or who have a recognized behavioral health disorder. SIM has also partnered with Metropolitan State University (MSU) Department of Social Work and Colorado State University Department of Social Work, which applied for the HRSA funding jointly. All three schools received HRSA funding. The SIM workforce workgroup remains connected to this work with a co-chair from DU and a sitting member from MSU. Please read more about the work the SIM team did with social work students at MSU in the Innovations and Opportunities section.

The Primary Care Office (PCO), which is funded by state and federal dollars, in the Colorado Department of Public Health and Environment (CDPHE) is a critical partner in health care workforce development. PCO services support professionals working in designated health professional shortage areas, who can receive funding to repay qualifying educational loans. Participants must see underserved patients at an approved clinical site for the entire service obligation. Examples of workforce types that are eligible include: Primary care, behavioral health, dental, nursing and nursing faculty.

In addition, the PCO has taken the lead in developing a Master Provider Directory (MPD) to better quantify the provider capacity in the state. In AY4 the SIM team will continue working with PCO to validate reports. This is an essential step in helping to quantify primary care and behavioral health workforce in the state.

Agency for Health care Research and Quality (AHRQ):

SIM transformation efforts are aligned with existing AHRQ opportunities and resources, particularly with EvidenceNOW Southwest (ENSW), 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." ENSW served 202 primary care practices in Colorado and New Mexico with practice transformation and quality improvement support, including on-site practice facilitation and coaching, expert consultation, shared learning collaboratives and EHR support.

ENSW is led by the Practice Innovation Program at the University of Colorado, Department of Family Medicine, which has been contracted to lead practice transformation activities for SIM primary care practices and TCPi practices. The fact that one department is responsible for implementation of all three initiatives helps to ensure operational alignment.

While the focus of ENSW is on cardiovascular health and the focus of SIM is on behavioral health integration and success with alternative payment models, the two initiatives promote development of complementary practice transformation competencies. As a result, SIM, ENSW and TCPi have hosted joint collaborative learning sessions (with breakout sessions specific to each initiative's focus) and continue to share resources. Additionally, many of the practice transformation organizations (PTOs) that provide support to ENSW practices also provide support to SIM practices. As described in the TCPi section, CHES will play a key role in assuring the PTOs are not duplicating efforts between the initiatives.

SIM and ENSW braided funds to support the state's RHC workforce.
A detailed diagram explaining the braided funding structure and discussion of how the work of RHCs was designed to support the goals of each initiative is available in the plan for improving population health.

In addition to ENSW, Colorado also aligns with IT MATTTRs 2, another AHRQ primary care initiative run out of CHES, which manages practice transformation organizations for SIM, TCPi and ENSW. IT MATTERS 2 uses a "train the trainer" approach in which practice facilitators are trained on medication assisted treatment (MAT) and opioid use disorder (OUD). A total of 300 providers in more than 45 practices will have access to Opisafe as well as an eight-hour buprenorphine waver course offered by the American Society of Medicine. Providers get the education free of charge and are compensated for their time.

d. State Initiatives (e.g., state-funded, private initiatives, etc.)

Regional Health Improvement Collaboratives (RHIC)

Center for Improving Value in Health care (CIVHC)

The Network for Regional Health Care Improvement (NRHI) has accelerated the formation of RHICs across the country to serve as a mechanism though witch key stakeholders in a community "can plan, facilitate ad coordinate activities required for transformation of the community's health care system," according to the Robert Wood Johnson Foundation. CIVHC is the only RHIC in Colorado officially recognized by the RHIC and is a SIM vendor. For more information on CIVHC's role in SIM, see the program reporting and monitoring section and for more information on CIVHC's work as a RHIC, please see the project summary.

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 the Patient Protection and Affordable Care Act and Internal Revenue Service (IRS) requirements to report on the community benefits they provide.

The Colorado Hospital Association (CHA) conducts an annual statewide community benefits survey of its member hospitals and health systems to promote transparency and improve the visibility of unique community health programs in the state. The CHA also provides toolkits and communication materials to members to help promote its community benefit activities.

While the SIM office has not directly collaborated with community benefit programs to date, RHCs might work with community benefit programs in AY4.

Local public health department activities (LPHAs) and local health education activities

SIM is committed to aligning with LPHA activities throughout the state. The plan for improving population health section 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

When identifying community priorities, RHCs were asked to review community health needs assessments and select topics that aligned, when possible. These assessments will also play an important role in guiding RHC project plans.

e. Independent Practice Transformation Programs in Colorado

Colorado has an abundance of locally-funded, independent practice transformation programs offered by each of the practice transformation organizations (PTOs) in Colorado. The PTOs, under the direction of CHES, provide practice transformation support to SIM practices, which makes it easier to avoid duplication and ensure alignment with other Colorado programs. To enable practices and PTOs to align various programs and support practices on a continuous transformation journey, PTOs have agreed to organize program offerings, including SIM, according to the Bodenheimer "Ten Building Blocks of High Performing Practices."

PTOs represent different types of organizations including: membership organizations, including the Association for Federally Qualified Health Centers and Rural Health Clinics, Independent Physician Associations (IPAs), Health Information Exchanges (HIEs), large health systems, a health plan, the Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) as well as non-profit organizations that have a mission to improve health and health care. These organizations offer their own programs, funded by a variety of philanthropic funders and delivered by their own practice facilitators. CHES publishes an electronic catalog (CHES catalog) of more than 35 program offerings available to practices in Colorado. A practice representative goes online, completes a basic practice assessment to identify strengths and gaps, and then filters available program offerings that address those gaps and connects them to a PTO offering the programs that interest them.

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

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 with support from SIM 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. SIM and the Denver Foundation jointly released an RFA in September 2015 for behavioral health transformation collaboratives (BHTCs). For more information, see 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. Molly Yost, technical assistance and policy manager for Project LAUNCH, is on the SIM population health workgroup and presented at a Medical Home Community Forum meeting, which was co-sponsored by SIM. We will continue seeking opportunities to partner and align throughout AY4.

BC3 – Better Care, Better Costs, Better Colorado

This was a collective effort to improve health care in Colorado with a diverse group of stakeholders, who aligned activities, engaged communities and supported existing initiatives. Started in 2014 by the Colorado Health Foundation, the initiative concluded in 2017, after a leadership change at the foundation. BC3 supported the SIM initiative and established similar goals. Six of the eight building blocks identified by BC3 matched the subject matter areas addressed in SIM workgroups. BC3's goal around integrated care delivery also matched SIM's stated objective. Through BC3 funding participating practices in Colorado

increased depression screening rates by 4% in urban areas, 9% in rural areas and 17% among children. Complementing SIMs goal of improved pediatric based metrics in Colorado participating BC3 practices improved adolescent nutrition and physical activity counseling by 28% and 13%, respectively, while improving BMI documentation by 14%.

The Colorado Opportunity Project

This joint initiative was recently launched by HCPF, 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. A key aim is to create a shared understanding of what opportunity looks like in Colorado and 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,[24] and HCPF'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 help Coloradans reach middle class 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 Project 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. 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 affect their ability to meet 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 allow individuals to progress along that pathway to economic opportunity. In AY4, the SIM office will focus on how to align efforts between Colorado Opportunity Project Liaisons and RHCs as both positions have similar aims.

2Gen

Stakeholders across Colorado, including state agencies that oversee health, human services, education, labor, and housing, have embraced a two generation (2Gen) approach to better understanding and more effectively meet the needs of Colorado families. By focusing on children and their adult caregivers simultaneously, 2Gen strategies break with traditionally fragmented approaches to service delivery and provide all family members with the resources, networks, and community support needed to break the cycle of intergenerational poverty and realize their full potential. The 2Gen approach, the Colorado Opportunity Project and other aligned initiatives demonstrate the interdependence between pediatric and parent outcomes. SIM continues to align with 2Gen and team members volunteered for the first conference held in AY3. The team also created a flier that illustrates how these two initiatives align. This partnership will continue in AY4.

Colorado Office of Early Childhood – Early childhood mental health strategic plan

The Early Childhood Mental Health (ECMH) Strategic Plan was developed in 2015 by the Early Childhood

[24] 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

Mental Health Unit at the Colorado Department of Human Services (CDHS) Office of Early Childhood. It outlines the strategic vision for early childhood mental health efforts in Colorado and encompasses the range of work in the state that focuses on social emotional development and early childhood mental health, which will collectively contribute to the plan's outcomes.

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

The ECMH Director at CDHS' Office of Early Childhood has participated on the SIM evaluation workgroup since its inception to help ensure that early childhood mental health issues are taken into consideration with evaluation efforts, findings and reporting. As part of the ECMH Strategic Plan workplan, a finance committee was convened to develop guidance for Medicaid payments for prevention-oriented behavioral health services for young children and their caregivers. While these services are outside of the core SIM efforts, they represent activities on the continuum of behavioral health supports in Colorado, and progress in this area will lead to increase access and availability. In addition, coordinated work continues between ECMH and SIM efforts to improve appropriate practice approaches to women experiencing pregnancy-related depression. There is a SIM-funded Children and Families Behavioral Health Integration Specialist at CDPHE, who connects this work to the population health efforts and coordinates with the Department of Maternal and Child Health.

Regional Center Task Force (RCTF)

The RCTF was charged with developing recommendations regarding the future size, scope and role of Colorado's three Regional Centers (RCs) serving people with Intellectual and Developmental Disabilities (I/DD). The task force developed 10 recommendations to address the requirements of HB 14-1338, including the person-centered, sustainable community supports required to serve not only residents of RCs but all Coloradans with I/DD. SIM is addressed in Recommendations 2 and 3:

- Recommendation 2 states, "Fully include services for individuals with I/DD in the capitated mental health system by basing access and reimbursement of services on the existence of behavioral symptoms, not diagnoses, and require Behavioral Health Organizations to actively recruit and develop provider networks." Specifically, 2.B.5 states, "The $65 million State Innovation Model (SIM) grant awarded to the State outlines a goal of integrated care for 80% of Coloradoans by 2020. Coordinated work is already occurring with primary care practices along with a workforce group. This recommendation should be taken to the SIM workforce workgroup and a plan developed to ensure that people with I/DD are not left out of this groundbreaking work."
- Recommendation 3 states, "Develop Guidelines, Training, and Clinical Tools for medical, behavioral and mental health Providers to deliver Effective services for the I/DD population in the community regardless of the complexity of needs." Specifically, 3.B.4 states, "Secure funding to augment recommendations and training efforts coming out of the SIM grant."

The recommendations (including those related to SIM) represent an ambitious multi-year commitment that will require collaboration between the legislature, various state agencies, community providers, medical professionals, families, advocates and others.

In AY4, the project manager for the RCTF will continue to collaborate with the SIM workforce and

population heath program manager to ensure open communication. The project manager for the RCTF is interested in the possibility of developing a training module related to individuals with co-occurring conditions of IDD and MH/BH that could be hosted on the University of Colorado Department of Family Medicine e-Learning platform.

C. Detailed workplans by driver

The SIM workplan is included in this report as appendix M1

Alternatively, click here to view the workplan in your web browser.

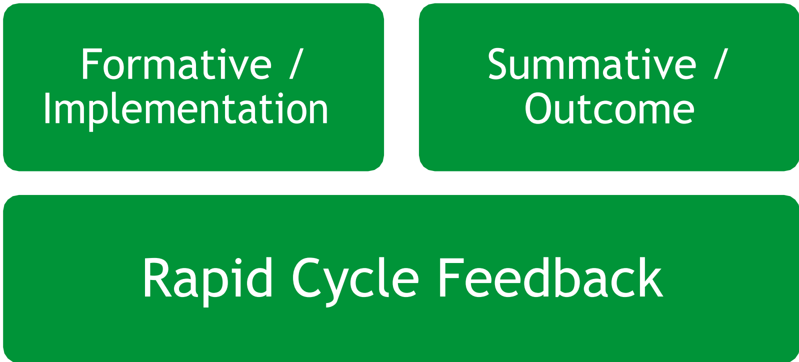
D. Program evaluation and monitoring

1. State-led evaluation

a. Evaluation approach

SIM onboarded TriWest Group, the state-led evaluation team, in April 2016, after a competitive bid procurement process. An updated logic model is *included as **Appendix E1*** and updated evaluation methodology, data analysis plan, repository of measures, and baseline data report are available upon request. These are "living" documents that are updated continually in response to program developments and rapid-cycle findings.

SIM's evaluation approach comprises three major components: formative/implementation, summative/outcomes, and rapid-cycle feedback. TriWest provides quarterly rapid-cycle feedback reports that contain a progress implementation dashboard, some consistent measures such as clinical quality measures (CQMs), and a special focus each quarter. Quarterly rapid-cycle reports will continue to be delivered throughout the life of SIM and will contain key process measures and practice Shared Practice Learning & Improvement Tool (SPLIT) assessment data analysis as available. The reports also often contain practice vignettes that take a deeper dive into qualitative data and field notes for a sample of practices to highlight key issues, challenges, and best practices. These rapid-cycle reports facilitate a continuous quality improvement process for the SIM office and partners to identify short-term successes, challenges, opportunities for course correction, and continued or additional support. In AY4, the SIM office will continue its work around dissemination and utilization of these rapid-cycle findings with stakeholder workgroups and key partners.



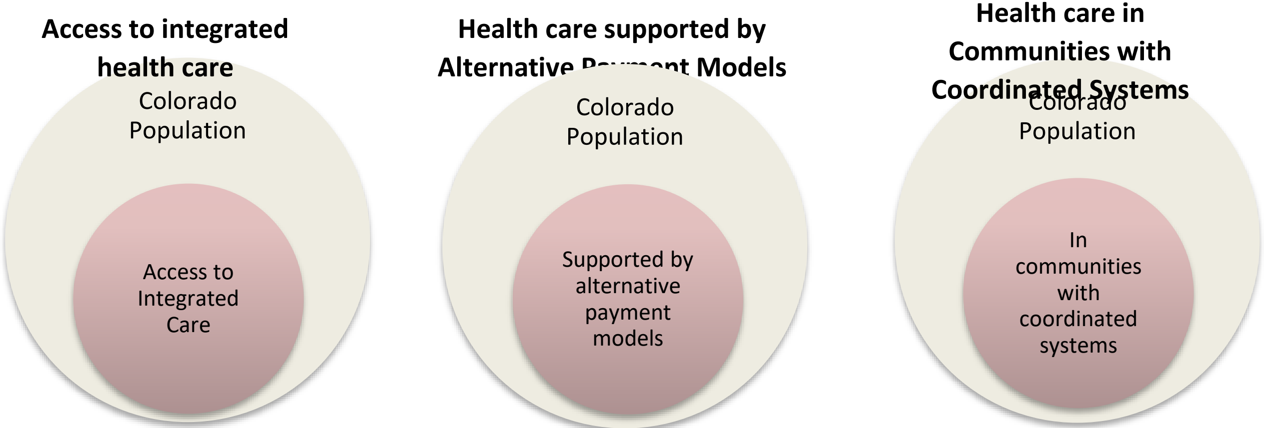
TriWest will also deliver annual reports and a final evaluation report that contain outcomes data and summative findings. In the final year of SIM implementation, TriWest will deliver a sustainability plan for

state-led evaluation efforts that specifies the systems, data, and other mechanisms to continue to monitor the effects of SIM efforts after completion of the initiative.

In addition to the streams of data from various partners, practices, and payers (detailed in the program monitoring and reporting section*)*, TriWest is conducting three rounds of key informant interviews and/or surveys with: 1) key stakeholders and partners, 2) Practice transformation organizations (PTOs), and 3) SIM practice sites, community mental health center (CMHC) bi-directional health homes, regional health connectors (RHCs), and local public health agency (LPHA) and behavioral health transformation collaborative (BHTCs) grantees. This qualitative data supplements the SPLIT assessment data and provides real-time, in-depth insights into SIM implementation. Stakeholder interviews will be completed again at the end of the program, and PTO/LPHA/RHC interviews and surveys will be completed annually, to demonstrate progress during SIM. TriWest is developing a process to conduct interviews with practices from each cohort and the CMHC bi- directional health homes to develop case studies related to the cost of transformation and other themes.

b. Approach for measuring overarching goal

The primary goal of the SIM project is to "Improve the health of Coloradans by increasing access to integrated physical and behavioral health care services in coordinated community systems, with value-based payment structures, for 80% of Colorado residents by 2019." There are three components within this "80%" goal. Each component is represented as a sphere in the diagrams below. SIM is implementing a series of efforts supporting the state's progress towards a health care system that improves the measures in each of these three components or spheres.



Each component of the overall goal is an ambitious undertaking when considered alone, and each is important in making progress towards integrating primary and behavioral health care with the goal of affecting 80% of Colorado's population. These three distinct "spheres" are mutually supportive but usually thought of separately, as illustrated above. SIM seeks to evaluate *both* changes within each sphere separately *and* changes to the intersection of the three spheres. Therefore, the evaluation will focus on 1)

documenting progress made in each of these three spheres during SIM implementation and 2) examining changes to the overlap of the three spheres.

c. Defining and measuring access to integrated care

Access to care most generally will be measured by use of All Payer Claims Database (APCD) data as defined in the SIM evaluation plan using standardized Agency for Health care Research and Quality (AHRQ) access to care metrics. Other sources of access data include access to care questions added to the Colorado Health Access Survey (CHAS). Integrated care will be assessed using SPLIT data, specifically the Integrated Practice Assessment Tool (IPAT) and the milestone activity checklist[25], and the medical home practice monitor. One measure of increased access to integrated care will use the number of patients served by providers scoring a specific integration threshold level on the IPAT, milestone checklist, practice monitor and access estimates from APCD data analysis.

TriWest is working with the University of Colorado Department of Family Medicine (UCDFM) and the SIM office to identify thresholds that indicate integration across various assessments and data sources. TriWest is defining the scores for the IPAT, practice monitor behavioral health integration questions, overall practice monitor score, and the various behavioral health integration questions from the milestone inventory, which signify that a practice is integrated. They are also estimating the correlations between these various scores to assess consistency across the assessments and to create a more comprehensive picture of integration.

In addition to the data sources listed above, increased provider access to telehealth capabilities, use of EHRs and health information exchanges (HIEs) to track patient outcomes, and data sharing among primary care providers will also be considered when estimating access to integrated care.

d. Defining and measuring value-based payment

The SIM office is working with participating payers to provide data on practice sites participating in alternative payment models (APMs) and the percentage of patients in each HCP-LAN defined category of APMs. This work has been difficult because it is not a familiar activity for the health plans. The data people within the health plan organizations come from varying backgrounds and health plan systems are set up in a variety of ways. For instance, one data system is structured around individual providers and lacks the ability to identify practices. To try and address these struggles the SIM office has taken a couple of steps to make the process easier.

First the SIM office redesigned the template used to be more accessible and simple. The team used examples from Washington for the new templates. Additionally, the template was simplified and now only contain data points the SIM office absolutely needs for SIM evaluation purposes. Beyond this, the SIM team has started to provide direct technical assistance one-on-one with the individual health plan data teams.

TriWest will use this payer-reported data to estimate increased use of APMs as demonstrated by an increase in the number of practices supported by APMs and an increase in the number of patients attributed to practices supported by APMs. Leveraging Milliman's cost of care calculations, TriWest will estimate cost decreases associated with increased use of APMs (compared with non-SIM practices). While Milliman is calculating return on investment (ROI) from the CMMI federal initiative perspective, TriWest will use key informant interviews with practices to obtain provider perspectives of ROI for participating in

[25] For cohorts 2 and 3, the SIM office worked with UCDFM to revise the milestone activity inventory. This assessment is now called the milestone activity checklist. Cohort 1 will continue to use the original inventory.

APMs and identify challenges encountered by practices adopting APMs. TriWest will also describe payer perspectives of ROI in moving toward greater use of APMs.

e. Defining and measuring coordinated community systems

To estimate progress in the third sphere of the 80% goal, TriWest continues its work with key partners and stakeholders to develop a coordinated community systems index that will combine data from key informant interviews and/or surveys with LPHAs, BHTCs, and RHCs, monthly RHC report data from the Colorado Health Institute (CHI), quarterly LPHA and BHTC grantee report data from the Colorado Department of Public Health and Environment (CDPHE), environmental scan findings from Health Management Associates (HMA), population health indicators and CHAS data. While progress has been made, this effort remains ongoing, as data sources are tested for utility for the index. TriWest has just completed and is in the process of reviewing a SIM "saturation" model that will be the initial foundation of this work. This will be finalized for the annual report in June 2018. The second part of the index, which will gauge levels of coordination, requires more work with current partners. Ultimately, themes will focus on collaboration efforts and ratings at the community level. Data will be associated with SIM practice sites and CMHCs to assess the degree of coordination between population health partners and efforts and SIM practice sites and CMHCs.

f. Defining sub-populations

TriWest is working with UCDFM partners and population health partners to define various populations for sub-analyses. Potential subgroups include adult and pediatric practice sites, rural, urban, suburban, and frontier geographic locations, practice size, practice type, and county level analysis.
TriWest will calculate various measures according to these sub-populations as part of the summative evaluation in the annual and final reporting.

TriWest will conduct analyses between cohorts to consider various changes to implementation for each cohort. For example, cohort 2 will use the streamlined set of building blocks and metrics as well as the simplified set of CQMs. Some cohort-1 practice sites participated in the Clinical Primary Care Initiative (CPCi) and a different subset participated in CPC+ starting in the second year of SIM implementation. Cohort-3 practice sites will have one year of SIM participation versus two years that cohorts 1 and 2 had. TriWest will examine impacts across the SIM program and aggregate cohort of practice sites as well as specific considerations for each cohort individually.

g. Identifying comparison data

TriWest is working on a strategy for identifying data from practice sites that are not part of the SIM cohorts. The state-led evaluation has two general goals that require use of such data. One is to assess movement toward, and achievement of the SIM goal that 80% of Coloradans have access to integrated care that is supported by APMs in coordinated community systems. Estimating the proportion of Coloradans who are supported by APMs and those in coordinated community systems will be done through comparisons using ACPD, payer data and geographic-based community-level data, all not at the practice site level. However, estimating access to integrated care as well changes in costs of care requires data at the practice-site level on integration for practice sites outside the SIM cohorts. TriWest is working with a new provider directory created by CDPHE to identify comparison practice sites within the APCD. If this directory can be used to "roll-up" individual providers to a practice site level, we will select a stratified random sample of practices to ensure representation across the state. This sample could be used to create an estimate of how many non-SIM practices are providing a level of integrated care as defined by measures of integration that can be observed in the APCD. The number of patients served, and overall practice-site capacity within a general geographic area could then provide a foundation for calculating an estimate of how many individuals likely have access to integrated care.

The other goal is to associate observed outcomes to SIM-specific efforts by eliminating external factors. The attribution to SIM drivers of changes in outcome measures such as utilization, cost or quality will be more credible if a comparison group of non-SIM cohort practice sites is developed. For measures that are calculated from the APCD, comparison groups can be matched based on known APCD (claims) characteristics. If we are unable to use the Provider Directory to aggregate individual providers to a practice site, then we will conduct the analysis at the individual patient level, comparing patients attributed to SIM versus non-SIM providers.

h. Actuarial analyses

Milliman, SIM's contracted actuary partner, calculates various cost and utilization measures on a regular basis. The nine core SIM cost and utilization measures are calculated quarterly on an aggregate basis and reported to CMMI. In addition to the aggregate calculations, Milliman prepares a cost and utilization report for each individual SIM practice site. The first quarterly reports with baseline CY2015 data were distributed to primary care practice sites in April 2017. Reports for each of the four participating CMHCs will be created and distributed once patient lists are reported to the Center for Improving Value in Health Care (CIVHC) for attribution purposes (by the end of the no-cost-extension period). These reports will continue to be delivered to individual sites on a quarterly basis throughout the SIM program.

In addition to the core SIM cost and utilization measures, Milliman calculates actuarial cost and utilization measures on an aggregate and individual practice site basis. These reports are delivered semi- annually (every 6 months) and feed into the cost projections, cost savings/avoidance, and ROI calculations.

To calculate ROI, Milliman delivers projected cost and utilization reports once annually. The first report was delivered in Q4 of year 2 and future reports will be delivered in Q2 of year 3 and Q2 of AY4. Milliman then compares projected cost and utilization with actual cost and utilization to develop cost savings/avoidance and ROI each year. The first cost saving/avoidance and ROI report will be delivered during the no-cost extension period in July 2017, and future reports will be delivered in Q4 of year 3 and Q4 of year 4.

Milliman also develops reports to inform payment reform and practice transformation efforts for SIM. These "pooling and credibility reports" include criteria for success of pooling models and approaches under provider payment model reforms, including approaches for determining credibility of insured member groups, and illustrative results from detailed commercially insured data in Colorado. The first report was delivered in Q1 of year 2, and future reports will be delivered annually in Q2 of year 3 and Q2 of year 4. However, the SIM team has not been receiving these reports, due to incomplete data and quality issues as reported to CMMI.

Risk adjustment reports discuss certain potential value-based payment models, risk adjustment methodology considerations, risk adjustment model selection issues, and the application of risk adjustment models in value-based payment models. The first report was delivered in Q4 of year 1, and future reports will be delivered annually in Q1 of year 3 and Q1 of year 4.

Predictive modeling reports use technology and statistical methods to search through large amounts of information, analyze it to predict outcomes for individual patients, and attempt to identify patients at risk for specific medical or behavioral conditions. The first general report was delivered in Q1 of year 2, and a report focusing on predictive modeling for depression was delivered in Q4 of year 2. Future reports will be delivered annually in Q1 of year 3 and Q1 of year 4.

Payment reform reports focus on criteria for success of payment model reforms, transitioning options for different practices, and plans for implementing various models and methodologies in Colorado

during the pre-implementation period and test years. The first report was delivered in Q1 of year 2, and future reports will be delivered annually in Q3 of year 3 and Q3 of year 4.

i. APCD data and analyses

The Center for Improving Value in Health Care (CIVHC) is the administrator of Colorado's APCD and provides quarterly claims data refreshes to TriWest and Milliman for evaluation and actuarial analyses. CIVHC also provides an annual data refresh to the federal evaluation team that have all claims data for submitting payers in the state dating back to 2011.

In AY3 there were APCD extract delays that in turn delayed reporting and evaluation activities. CIVHC transitioned database vendors during the AY2 NCE and the Department of Healthcare Policy and Financing (HCPF) transitioned Medicaid Management Information Systems (MMIS) vendors in Spring of 2017. With two large system changes over this period it is not surprising that HCPF delayed sending Medicaid extracts to the APCD until issues could be sufficiently addressed. In February 2018, HCPF resumed submitting Medicaid data; with this progress TriWest and Milliman received ACPD extracts that include Medicaid, commercial, and Medicare Advantage data through calendar year 2017 and Medicare Fee for Service (FFS) through June of 2017.

In addition to providing claims data to key evaluation partners, CIVHC worked with stakeholders to develop a standard attribution methodology to run through APCD data for SIM reporting and evaluation purposes. CIVHC runs attribution and provides this data as a supplementary file to the full APCD data refresh on a semi-annual basis. As SIM primary care practice sites update their National Provider Identifier (NPI) information annually, CIVHC provides updated attribution data to TriWest, Milliman, and the federal evaluation team. CIVHC will provide CMHC attribution and claims files to TriWest and Milliman based on CMHC self-reported patient lists every six months. Read more information in the program monitoring and reporting section.

CIVHC has developed methodologies and programming for claims-based proxy measures for each of the CQMs. Baseline CY2015 measures were delivered will be delivered on an annual basis for CY 2016, 2017, and 2018. These proxy measures serve as benchmarks for the CQMs and will be reported to CMMI in the core metrics template annually.

In year 4 the SIM office will continue to work with CIVHC to identify a path for providing Medicare data to the SIM practice data aggregation tool.

Other data collection and reporting partners and processes for CMMI core metrics and other reporting are detailed in the program monitoring and reporting section.

2. Federal evaluation, data collection and sharing

a. All Payer Claims Database (APCD) data

The Center for Improving Value in Health Care (CIVHC) provides annual APCD data extracts to the federal evaluation team with data from all payers who submit data to the APCD, including the private and public payers participating in SIM. It includes claims data for all lines of business, age groups, regions, provider types and settings, and procedure codes. CIVHC creates a composite person identification to serve as a common identifier across payers. The last extract and data element dictionary were delivered in November of 2017 and contained data from January 2012 through December 2016 (Medicare FFS through December 2016 and Medicare Rx through December 2015). These extracts will continue to be delivered every August on an annual basis throughout the life of SIM unless the federal evaluation team identifies a different timeline or process to conduct federal evaluation activities.

b. Attribution

The annual APCD extract includes beneficiaries attributed to SIM practice sites as well as all other beneficiaries in the APCD for comparison purposes. CIVHC runs the standardized attribution methodology developed for SIM reporting and evaluation purposes on a semi-annual basis (for more information, see the program monitoring and reporting section. Through the attribution process, CIVHC associates every beneficiary in the APCD with a provider National Provider Identifier (NPI). Provider NPIs that are self-reported in the SIM practice roster are rolled up to the SIM practice site level to attribute beneficiaries to each SIM practice site. CIVHC provides a supplementary attribution file to the federal evaluation team with each annual APCD data extract. CIVHC provides the more frequent, semi-annual updates to attribution to the federal evaluation team upon request.

c. Payment support data

The SIM office continues to work with participating payers to provide data for SIM reporting and evaluation. Pending the receipt of CY2015 baseline data from all payers, the SIM office shared a list of payers supporting each SIM cohort 1 practice site with an APM. In preparation for sharing 2017 eCQM data with payers, the SIM office asked each payer to update the list of SIM cohort 1 and 2 practices they support through an APM. Once the SIM office receives updated information from each payer, the team will share the comprehensive list with the federal evaluation team. The SIM office is also in the process of collecting payment support information for each of the practice sites that applied for cohort 3. Once the team receives a final list from payers, the SIM office will share the list of payers supporting each practice site that is accepted into cohort 3.

d. Consumer focus groups

Early in SIM year-1 implementation, the SIM office collaborated with HCPF to provide Health First Colorado (Medicaid) client information to the federal evaluation team to conduct consumer focus groups. HCPF's data team pulled data for beneficiaries attributed to SIM cohort 1 practice sites, stratified by behavioral health organization (BHO) members and "non-BHO" members. The data contained the beneficiary's phone number, address, sex, and age. The SIM office worked with the federal evaluation team and HCPF to ensure that all appropriate data sharing agreements and consent forms were in place, as well as appropriate incentives and communications to Health First Colorado clients. The SIM office will continue to cooperate with the federal evaluation team to provide data needed for future focus group activities in year 4.

e. Key informant interviews

In SIM year 3 the SIM office provided SIM provider and key stakeholder information to conduct key informant interviews. The SIM office worked with the federal evaluation teams to coordinate key informant interview outreach and efforts. The SIM office will continue to cooperate with the federal evaluation team to provide data needed for future key informant interview activities in year 4.

f. Coordination with state-led evaluation efforts

The SIM office evaluation program manager and a representative from TriWest's state-led evaluation team join monthly coordination calls with the federal evaluation team. During these monthly coordination calls the SIM office includes the relevant SIM office program managers and subject matter experts in a continued effort to inform the federal evaluation of the initiative. The SIM office provides data and information as requested and shares the state-led evaluation quarterly rapid-cycle feedback reports. The SIM office will continue to participate in these regular communication opportunities.

The SIM office has obtained appropriate data sharing agreements for all data sharing needs with the federal evaluation team. The SIM office will continue to work with the federal evaluation team to

understand future data needs and work with identified partners to execute the necessary data sharing agreements. The SIM office agrees not to receive additional reimbursement for providing data or other reasonable information to CMS or another government entity or contractor.

3. Program monitoring and reporting

a. Model participation metrics

In year 4, the SIM office will continue to collect data from vendor partners, practice sites, and payers for internal program monitoring, reporting core metrics to CMMI, and evaluation. The SIM office has developed the processes for collecting core metrics data from vendor partners on a quarterly basis. For example, the Colorado Telehealth Network (CTN) reports on the number of sites enabled for telehealth, while the Office of Behavioral Health (OBH), The Colorado Department of Public Health and Environment (CDPHE), and UCDFM each report on the number of provider education activities conducted. The SIM office conducts quality assurance checks, aggregates the data, and reports these model participation metrics to CMMI each quarter. The SIM office and partners will continue to follow this process during year 4, reporting on calendar year quarters. An example of timing is that calendar year quarter 3 (July - September) data will be reported to the SIM office by the end of October and will in turn be reported to CMMI in the November quarterly report.

Some process measures are reported biennially. The Center for Improving Value in Health Care (CIVHC) runs attribution, utilizing a standardized methodology developed by SIM stakeholders for reporting and evaluation purposes, twice per year. All payer claims database (APCD) attribution is run once at the onset of each cohort, and then again after practice sites update their SIM practice rosters after the first year, reflecting updated NPI information. The SIM office provides guidance for each SIM practice roster update to ensure practice sites report the most complete and accurate list of NPIs possible, to allow for more complete and accurate data, such as patient attribution and cost and utilization measures. Since the standardized attribution methodology applies only to primary care practice sites, participating Community Mental Health Centers (CMHCs) plan to self-report their patient lists to CIVHC twice per year. The schedule for CMHC patient lists intentionally aligns with the timing of the cohort attribution runs.

A few model participation metrics are reported annually. SIM participating payers submit calendar year data that are aggregated and reported under the Population Impacted by SIM and Practice Sites Participating in SIM metrics. Each of these metrics are sub-divided by payment model categories. The SIM office waits to report on these metrics until annual data are available from all payers. This process will continue in year 4.

With year 3 the SIM office retired 2 model participation metrics and added a few others. The original metrics regarding the number of participating Local Public Health Agencies (LPHAs) and Behavioral Health Transformation Collaboratives (BHTCs) were achieved by September of 2016 and were officially retired per CMMI project officer approval August 1, 2017. In lieu of these retired metrics the SIM office reports on, the Total Number of Community Members Participating in Behavioral Health and Wellness Education by LPHAs Supported by SIM and The Total Number of Participant Referrals to Behavioral Health Community Resources by BHTCs supported by SIM. In year 3 the SIM office also began reporting on metrics related to Health Information Exchange (HIE) connectivity of SIM participating practice sites and the number of SIM small grant awardees. All these metrics are reported quarterly by the SIM office and will continue to be reported in year 4.

b. Model performance metrics

In addition to the process metrics reported by vendor partners, the SIM office has created processes to report key model performance measures. Milliman is calculating the core aggregate cost and utilization

metrics on a quarterly basis. TriWest is using AHRQ methodology to report the access to care prevention quality composite measures annually. CIVHC is calculating claims-based proxy measures for each of the clinical quality measures (CQMs). The first round of CQM proxy measures were reported to CMMI in the last quarterly progress report (QPR). Once complete 2016 and 2017 claims data are available in the APCD, CIVHC will calculate updated values for these claims-based proxy measures.

The population health indicators were selected to align with the CQMs that SIM practice sites report on a quarterly basis. These indicators provide a statewide population-level benchmark; however, as these measures tend to remain stagnant overtime, Colorado SIM does not expect to see much movement during the course of the initiative. SIM regional health connectors (RHCs) have aligned their target areas with the CQMs, which in turn, align with the population health indicators (please see the plan for improving population health section*)*. CDPHE is collecting and reporting the core SIM population health indicators once annually. During the first year of implementation, the SIM office worked with CDPHE to focus in on the behavioral health indicators that align with SIM behavioral health CQMs. The population health indicators that align with SIM physical health care CQMs are still being reported to the SIM office by CDPHE and used for internal monitoring with the population health workgroup and state led evaluation; however, they are no longer reported to CMMI. As existing population health survey data (from BRFSS, vital statistics, etc.) becomes available at different points throughout the year, CDPHE reports all the indicators to the SIM office once per year and will be reported to CMMI as part of the November quarterly report.

c. Practice-level data

The SIM office will continue to collect CQM data from practices on a quarterly basis and aggregate the data for reporting to CMMI. Cohort-1 primary care practice sites have been reporting quarterly CQM data for over two years. Cohort-2 primary care practice sites have reported 3 quarters of CQM data and will continue to report quarterly through year 4. Following the release of funding for the CMHCs in year 2, the SIM office contracted with Health Management Associates (HMA) to facilitate a consensus among the four participating CMHCs regarding consistent data reporting of attribution, CQM reporting, and number of providers participating in SIM. HMA completed this work in year 3 with CMHCs reporting quarterly CQM data ongoing through AY4. Aggregate CMHC and primary care practice sites CQM data are reported separately to CMMI quarterly.

In addition to the CQM data reported by primary care practice sites and CMHCs, each site reports baseline and annual/semi-annual data for a set of assessments via the Shared Practice Learning and Improvement Tool (SPLIT). UCDFM, TriWest, and the SIM office each have a role in analyzing the SPLIT assessment data to report back to practice sites, inform program implementation, and feed into the state-led evaluation.

d. Participating payer data

The SIM office has been working closely with the Multi-Payer Collaborative (MPC) to identify and refine the key data elements necessary for CMMI reporting and state-led evaluation. Together with participating payers, the SIM office updated the data collection template that payers submit annually. The SIM office aligned the data request and guidance with the national HCP-LAN data collection effort wherever possible. Payers were asked to submit CY2015 baseline data for cohort-1 practice sites by Dec. 31, 2016.

The SIM team has data from five of the six payers for baseline. Three payers submitted full or partial 2016 data; one health plan representative said the company will not be able to submit any data for 2016; and three of the payers have submitted full or partial data for 2017. The team and continues to follow-up

with each payer to understand the challenges and provide guidance. While some payers submitted data for the national effort, it is a manual, onerous process for payers to pull this data at the state level. It is also a manual, onerous process to pull the data at the cohort level of SIM practice sites. Payers are still working to understand, categorize and pull their data, according to the relatively new HCP-LAN APM categories. Finally, some payers are hesitant to provide payment data () to the state. The SIM office is continuing to work through these challenges with payers and has changed the request from total dollar amounts paid to the percentage of payments per CMMI guidance. (See metric template for definitions ***Appendix L1***)

The SIM office has begun sharing eCQM data with payers. As practice sites and clinical health information technology advisors (CHITAs) have provided feedback related to data quality issues, and that they do not trust the data until the measures reflect a full calendar year worth of data, the SIM office is sharing data once annually. The measures that practice sites report in Q4 should cover the full calendar year (January – December) of the previous year. The eCQM data is shared with payers only for the practice sites that they support with an alternative payment model (APM) through SIM. Cohort-1 practice sites were provided with an option to opt-out of the SIM office sharing their eCQM data with payers on their behalf. However, cohorts 2 and 3 practice sites do not have the opportunity to opt out. The SIM office also drafted and executed cooperative agreements with each payer that prevents payers from sharing practice-identifiable data without the practice site's permission and allows payers to use the data only for purposes contained within existing payment agreements or contracts.

e. Gaps in data

The SIM office continues to work on identifying and developing strategies to address gaps in existing data. For example, behavioral health data is lacking in the APCD. To supplement the analysis TriWest, Milliman and CIVHC conduct for SIM evaluation activities, the SIM office worked with the Department of Health Care Policy and Financing (HCPF) to provide the Behavioral Health Organization (BHO) encounter data flat file to these partners once a year. Because the file contains substance use disorder data, the SIM office and HCPF identified an exception to 42 CFR part 2 and draft the necessary data sharing agreements with each vendor. This data will help provide a more comprehensive picture of the impact SIM is having on cost, utilization and other claims-based measures.

The SIM office continues to work with CMMI to identify a way to obtain Medicare data for inclusion in the data aggregation tool for SIM practice sites, as well as for reporting and evaluation purposes. The SIM office provided a concept paper to CMMI outlining use cases for all three purposes and has followed-up with CMMI on various data sharing agreements in place and potential paths forward. In AY4, the SIM office will continue to pursue CIVHC as a qualified entity to pass Medicare data through to the data aggregation tool. The SIM office has also worked with TriWest and Milliman to identify the reports available via ResDAC and will submit a request for research (SIM evaluation and reporting) purposes.

f. Care experience measure

The SIM office has pursued several strategies to identify a care experience measure to monitor during the program. The SIM office attempted to incorporate commercial beneficiaries into HCPF's annual CAHPS survey administration, as well as leverage a HCPF pilot to administer the clinician and group PCMH CAHPS survey with a small sample of practices. While the SIM office was unable to leverage these existing efforts initially, we have worked with HCPF to include a sample of SIM primary care practice sites in their next round of CAHPS. Results should be available near the end of year 3. Additionally, TriWest has worked with UCDFM to create a close out survey for practices. This close out survey includes the option for practices to share data with TriWest about practice's care experience metrics. This survey is with cohort-1 practices sites and once analyses are performed the SIM office and TriWest can determine if data

collected is of sufficient quality to supplement the HCPF CAHPS data.

g. Accountability targets

The SIM office worked with key partners and stakeholders, and conducted research to identify benchmarks, to set accountability targets for core metrics reported to CMMI. For many of the metrics, baseline data was not available until early 2017. Since the SIM office and stakeholders wanted to make data-driven decisions based on baseline data and existing benchmarks, accountability targets were included in the Q1 2017 report. Some accountability targets are not yet determined, such as CMHC CQMs and payer/payment metrics, as we are waiting to have more complete baseline data to make appropriate projections. Any additional accountability targets will be added to the CMMI core metrics reporting template as they are determined. In AY4 the SIM office will review accountability targets and update as necessary based on stakeholder feedback and updated data. Example: Developmental Screening and Maternal Depression Screening CQMs for primary care practice sites

h. Proposed changes to core metrics table

The SIM office made several additions and replacements to the core metrics table for reporting to CMMI in year 3. There are no proposed changes to the core metrics table for AY4. The core metrics table is included in ***Appendix L1****;* retired metrics are noted in the status column, added metrics are highlighted in beige and modifications are included in the notes section.

Previous changes to the core metrics template included the 2017 simplified CQM measure set, parsing out pediatric obesity into 3 separate components as measure is structured, and paring down the population health indicators to include only behavioral health indicators that align with SIM COMs.

Colorado SIM measure summary table

CQMs	Population Health	Cost and utilization	Model Participation (process)	Access to Care	Additional Evaluation measures
Depression Screening	Anxiety disorders among adults	Total cost of care	Payment reform (practices/beneficiaries in APMs)	Prevention quality chronic composite	Access to *integrated* care (IPAT, CHAS)
Diabetes: Hemoglobin A1c	Adults being treated for mental health	Out of pocket expenditures for consumers	Practice transformation (practices, providers, beneficiaries in cohort)	Prevention quality acute composite	Client experience of care
Hypertension	Prenatal care counseling about maternal depression	Admissions	Population health (LPHAs, RHCs, provider education)	Pediatric quality overall composite	Payer/provider ROI
Obesity: Adult and Adolescent	Adults who are currently depressed	Psychiatric admissions	HIT	Prevention quality overall composite	Workforce and policy efforts
Developmental Screening	Suicide death rate	Readmissions	(broadband, CQM reporting, HIE connectivity)		Coordinated Community Systems Index
Maternal Depression Screening	Binge drinking	Psychiatric readmissions			Collaboration, stakeholder engagement
Substance Use Disorders: Alcohol and other drug dependence, Tobacco, and Unhealthy Alcohol Use	Developmental screening for children	Emergency department (ED) rate			physical population health metrics
Asthma	Non-medical opioid use	Psychiatric ED rate			SPLIT assessment data
Fall Safety	Current smoking among adults	Follow-up after hospitalization for mental illness			Key informant interviews (challenges, successes, lessons learned)
	Heavy alcohol consumption	Actuarial calculations			

i. Monitoring newly-identified risks

The SIM office continues to monitor risks identified in the original operational plan and provide updates via quarterly reports to CMMI. The risk mitigation section of the recent quarterly report is included as ***Appendix L2***. The following risks have emerged since submission of the original operational plan. The SIM office will continue to monitor and address these risks throughout AY4.

j Practice transformation:

Lack of consistency in support delivered by practice transformation organizations (PTOs): cohort-2 practices can choose between 18 PTOs to deliver practice transformation support to their practices and may work with two separate PTOs for SIM alone - one to provide a practice facilitator (PF) and one to provide a CHITA. While this model maximizes flexibility for practices, affording larger health systems the opportunity to offer inhouse support and allowing practices to select a PTO with whom they have previously worked, it presented challenges in ensuring that all PTOs are performing up to a common standard and consistently disseminating information.

Mitigation strategy: The SIM office worked with UCDFM to determine a standard, minimum set of competencies for CHITAs that will be adopted across all PTOs. Additionally, the SIM office and UCDFM revised the field note structure that PFs and CHITAs use to record interactions with practices. Instead of being a free text field, the note will include more discrete fields to capture information that allows the SIM office to assess consistency. In AY4, the SIM office will continue to host monthly PTO office hour webinars to communicate key messages directly to PFs, CHITAs and other representatives from PTOs as well as offer them a forum in which to ask questions and share concerns, successes and ideas. Partners at UCDFM are adjusting the training they provide via quarterly in-person training, webinars and collaborative learning sessions based on findings from rapid-cycle feedback reports from TriWest and suggestions made in surveys completed by practices.

k. Population health:

Low ratio of RHCs to SIM practices: The SIM office supports 21 RHCs throughout the state, one in each health statistics region (see the plan for improving population health section for a detailed description of the program). Given the high number of practices participating in SIM and the large geographic regions that some RHCs are expected to cover, concerns have been raised that RHCs will not have the time or capacity to support each practice and may be spread too thin to have a substantial impact. For the state-led evaluation, TriWest is relying on the Colorado Health Institute (CHI) to collect data from each RHC. CHI will share the monthly report and social network analysis data with TriWest, which will feed in to the coordinated community systems index. TriWest will also conduct annual key informant interviews with the RHCs (please see program reporting and monitoring section for more information). The SIM office will continue to monitor progress based on the metrics table that CHI submits to SIM on a monthly basis (included as ***Appendix C1***).

Mitigation strategy: RHCs will meet with PFs, many of whom support multiple practices in a region, as well as review practice improvement plans from each practice, to identify common needs and themes. RHCs will select common themes that align with the priorities they have selected for their region and focus their efforts in those areas. RHCs will then be able to more efficiently disseminate information by bringing together groups of PFs or practices that have a common interest for trainings, webinars, and meetings. Additionally, because RHCs will be sharing information with each other across regions, there may be opportunities for a practice in one region to be matched with training or practices addressing similar issues in another region. The SIM office will continue to monitor this risk as the RHC program moves further into implementation.

l. Health information technology (HIT):

Delayed hiring and contracting of key personnel to complete HIT activities:

The SIM office completed a stakeholder-driven process to identify the top two prioritized use cases during the summer and fall of 2016. The plan was to hire a technical architect, housed within the state Office of Information Technology (OIT), to determine the technical requirements and specifications required to support prioritized use cases. Additionally, Deloitte Consulting was contracted to complete a SIM HIT implementation roadmap meant to link the use cases to the technical requirements and ensure that the business case for providers and payers was clearly articulated in the roadmap. Due to delays in contracting, Deloitte did not begin work until April 2017. Additionally, despite months of interviewing candidates, the SIM office was not able to secure a technical architect at the salary range offered. These delays have impacted the SIM timeline for procuring the HIT long-term solution.

Mitigation strategy: SIM negotiated with the state OIT to use its existing technical architecture staff for the remainder of the NCE period to work with Deloitte on the implementation roadmap and start outlining the technical requirements and technology specifications to support an eCQM registry. OIT will start with an assessment of exiting technology and assess format and capacity. The Office of eHealth Innovation (OeHi) has provided consultation and guidance during this period. The office will work with OIT on a project plan and ensure SIM is maximizing the resources available during the NCE. Additionally, HCPF has secured a master HIT consultant. After discussion with HCPF HIT experts and OeHi, SIM will include a request for a technical/data architect in that contract to maximize resources available to support AY4 HIT goals.

m. Payment reform:

Insufficient avenues for communication between payers and practices that participate in SIM:

As previously outlined, the SIM office has received feedback from several cohort-1 practices that communications with payers have been insufficient and confusing. Several practices have spoken with payer representatives, who were unfamiliar with SIM or provided misinformation about the initiative. In AY4, the SIM team will continue to encourage more regular communication between participating payers and practices to ensure that practices have clear information regarding the details of APMs. However, the fact that the SIM office must be blind to the specific details of private payers' models presents a challenge to clear communications. The team can recommend steps, has created a communication template and suggests timelines for this type of communication. The team also created a payer podcast (https://soundcloud.com/user-118904494/payment-support-podcast) and published several payer-related resources on the SIM website.

Mitigation strategy: The SIM office has worked with members of the MPC to review and vet language that will be provided to cohort-2 practices regarding which payers have indicated support for that practice. This language includes a payer-specific contact to whom practices can direct questions. For cohort-1 practices, many payers identified a high-level director or other leader in the organization as the contact for practices. However, many times these individuals did not have the time to respond to practice questions. Additionally, some practices found that their existing contact at a payer, responsible for the day-to-day details of contracting, was unfamiliar with SIM. For cohort-2, the SIM office has asked each payer to identify a contact or contacts that have the capacity to respond to a high volume of practice inquiries. The SIM office is also compiling talking points about SIM, a list of frequently asked questions, and protocols for who to contact in the SIM office with additional questions. These resources will be disseminated to all payer contacts as a means of ensuring that all payers provide consistent information and messaging to SIM practices.

n. Project management structure

HCPF serves as the fiscal agent for the Colorado SIM office. The SIM initiative receives funds from both CMMI (up to $65 million via a cooperative agreement) and from the Colorado Health Foundation (up to $3 million via a grant). An accounting technician (0.8 FTE), purchasing agent II (0.5 FTE), budget analyst (0.1 FTE), and grants administrator (0.1 FTE) who work elsewhere in HCPF, but not directly within the SIM office, help to provide financial and administrative oversight to the SIM initiative, ensuring accountability of the SIM office staff. The SIM office directly monitors the work of multiple vendors. The diagram following this section names the vendors with which the SIM office intends to contract in AY3, as well as delineates their major responsibilities by primary SIM driver.

Since submission of the original operational plan, the SIM office identified the need to have a dedicated staff member with knowledge of state procurement processes to streamline efforts around drafting, renewing, monitoring, and executing contracts. As a result, the SIM office hired Joseph Rodriguez as an administration and contracts program assistant II. With this role filled, the SIM office worked to identify staff roles and responsibilities related to contracts, as outlined in the chart below.

Administration and contracts program assistant	Content expert	Vendor liaison
• Initiates drafting request and coordinates to contract point person to start drafting Statement of Work (SOW) • Completes required supplementary documents for contracts and amendments • Creates and maintains deliverable and substitution/amendment tracking system • Receives and processes invoices • Uploads contract/procurement documents to SharePoint • Tracks deliverables and deliverable substitutions - ensures deliverable tracker is updated • Ensures deliverables	• Reviews and approves SOW • Reviews and approves contract amendments • Reviews and approves deliverables • Participates in regular check ins (weekly calls, etc.) to provide guidance to vendor and ensure alignment with other components of SIM	• Main point of contact for procurement – drafts SOW and amendments; leads iterative process with procurement to answer questions, make edits, and finalize contract • Schedules meetings, coordinates requests for information across vendors

While the administration and contracts program assistant II performs tasks that are standard to all contracts, such as processing invoices, each contract is assigned a content expert (generally a manager), who possesses the subject-matter expertise necessary to guide the overall content of the contract and to review submitted deliverables for accuracy. Additionally, when needed, a secondary point person, called a vendor liaison, may be appointed to assist the content expert in his/her interactions with a particular vendor and handle the more time-consuming details of contract monitoring. This structure ensures that there is sufficient capacity within the SIM office to

monitor all contracts across various work streams.

The SIM office has several methods for monitoring contracts. Because HCPF compensates vendors according to deliverable-based contracts, in which a vendor is paid a set amount for a given work product, accountability mechanisms are built into each contract. Tangible work products that are critical to the success of SIM are expressed as deliverables and included in these contracts. Vendors turn in deliverables, generally on a monthly basis, which are reviewed by SIM management. If a deliverable fails to demonstrate sufficient progress toward SIM goals, the SIM content expert assigned to the contract requests revisions or changes. If revisions are deemed unacceptable, payment for the deliverable is withheld and is not be disbursed unless a sufficient product is provided. Deliverables take on a variety of forms such as quarterly progress reports meant to provide a summary of successes and challenges to more programmatic products, such as a recording of a training webinar that was produced. Most vendors are also required to provide metrics to the SIM office, which the SIM team uses to populate quarterly reports to CMMI. All SIM contracts also include standard deliverables, which include a communications plan and business continuity plan, which outline mitigation strategies for common risks, such as turnover in key personnel.

In AY4, the SIM office will continue to hold regularly-scheduled meetings with all vendors to ensure continued progress. For example, key staff from different vendors meet with key SIM staff for regular meetings to discuss accomplishments and challenges. Agendas are drafted, and action items are tracked across meetings. The SIM office might schedule longer meetings to address issues around program implementation. SIM staff sit on advisory groups for several vendors. For example, in addition to meeting regularly with CHI for contract monitoring, the SIM program implementation manager sits on the RHC administrative workgroup that convenes monthly to provide guidance on the program rollout. These advisory groups provide SIM staff with an additional avenue for monitoring contract implementation while engaging with individuals from outside the SIM office.

Additionally, the SIM team meets with vendors to ensure they have sufficient processes for monitoring subcontracts. For example, the SIM office UCDFM drafted a survey of SIM practices with questions about overall experience in SIM and satisfaction with the PTOs with whom they were matched. The PTOs are subcontractors of UCDFM. Raw data from the survey was provided to the SIM office to gain an understanding of UCDFM performance as well as its contracted PTOs. In addition, the quality assurance committee drafted a process to identify and address PTO performance issues. See ***Appendix F5*** for more information.

All SIM vendors are expected to regularly participate in SIM stakeholder workgroups and, when necessary, to present challenges to the SIM steering committee and advisory board. For example, the population health workgroup has played an active role in ensuring that CHI meets its contractual obligations to the SIM office and that each deliverable is addressed in a manner that best serves the overall aims of SIM. Similarly, the practice transformation workgroup is a key forum through which UCDFM and the Colorado Behavioral Health Care Council garner feedback on elements of implementation. While stakeholder workgroups are not directly responsible for holding vendors accountable, conversations that take place during these meetings ensure that a broader group of experts, beyond SIM office staff, provide guidance on key areas of implementation. These conversations may, in turn, guide the content of new contracts or initiate amendments to existing contracts.

The SIM evaluation manager shares quarterly rapid-cycle feedback reports produced by TriWest with all SIM staff, including program managers (who generally serve as content experts for contracts). Program managers are required to include rapid-cycle findings as standing items during workgroup meetings, looping in both vendors and other key stakeholders on progress made toward addressing issues

identified in the rapid-cycle reports. (For more information about Rapid Cycle feedback reports, see the state-led evaluation section).

In AY4, the SIM office will continue to assess its strategy around contracting processes and adjust as necessary. The administration and contracts program assistant II will continue developing and improving processes and sharing these changes with the team.

o. Maintenance of program operations beyond SIM funding period:

The SIM office has established strong partnerships with organizations and groups that will continue to sustain progress beyond the SIM funding period.

Practice transformation: Facilitated by the practice innovation program at UCDFM**,** the Colorado Health Extension System (CHES) convenes numerous PTOs across the state to achieve better population health, lower costs and an improved experience of care for patients, families and health care teams. PTOs that support SIM practices participate in CHES, as does CHI, which deploys RHCs. The Colorado SIM director and program implementation manager participate in CHES meetings, including meetings of the CHES steering committee. CHES has played a key role in coordinating PTOs prior to SIM for initiatives such as the Comprehensive Primary Care Initiative (CPCi) and EvidenceNOW Southwest. As PTOs continue to support practices in Colorado via new initiatives, CHES team members, most of whom work at UCDFM, will possess the institutional knowledge needed to ensure that lessons learned from the SIM initiative are incorporated into statewide practice transformation efforts moving forward.

Payment reform: The Colorado Multi-Payer Collaborative (MPC), described in further detail in SIM approach to payment reform section, was initially convened to support CPCi. The group now plays a critical role in advancing the objectives of SIM as well as CPC+. As funding comes to an end for the SIM initiative, the group will continue to coordinate support for CPC+. Furthermore, members of the MPC are exploring avenues to formalize an ongoing partnership with Oregon Health Sciences University, which facilitates MPC meetings, beyond the term of SIM. As payers have identified behavioral health integration as a key priority under SIM, it is anticipated that the MPC will continue to focus on efforts that sustain progress toward integration in the long-term. A leadership engagement meeting is scheduled for members to recommit to the goals of the MPC. This will be a conversation with MPC members and payer leadership, and formal commitment will be crafted and formalized by the MPC.

Population health: CDPHE plays a leadership role in guiding the population health efforts of SIM. Dr. Tista Ghosh, deputy chief medical officer at CDPHE, chairs the SIM population health workgroup. Under Dr. Ghosh's leadership, the population health workgroup recommended that CDPHE (with SIM funding) contract with HMA to undertake an environmental scan of efforts related to behavioral health across the state and to issue a call to action based on identified needs and gaps (more information about the environment scan is provided in the plan for improving population health). CDPHE leadership is committed to providing an ongoing forum for sustaining progress made under SIM and will continue to coordinate efforts with statewide partners beyond the term of SIM funding.

HIT: The SIM office partners with OeHI and other state groups to develop and implement its HIT strategy. Carrie Paykoc, Colorado's HIT coordinator, serves as one of three co-chairs for the SIM HIT workgroup and is closely involved with SIM HIT efforts. Carrie has helped guide efforts to create a state HIT roadmap and build the foundation for a long-term statewide HIT solution or solutions that will aggregate clinical and claims data. The HIT coordinator will continue to ensure that progress made with SIM funding is sustained beyond the funding period. SIM funded a data architect in AY3. This position will be shared with HCPF Health information Office (HIO) through the master HIT consultant contract. While this individual's primary responsibility will be to build the foundation for a long-term HIT solution with SIM

funding, HIO will continue to fund this position beyond the SIM initiative and continue to partner with OIT, ensuring continuity in implementing the solution.

4. Fraud abuse prevention, detection and correction

Colorado has a robust set of statutes, programs, and processes to prevent, detect, and correct health insurance fraud and abuse. The SIM office anticipates that payment reform and other initiative activities will fit into the statutory and regulatory mechanisms outlined here.

a. Medicaid

State statute

The State of Colorado has a Medicaid anti-fraud statute to prevent the submission of false and fraudulent claims to the Health First Colorado (Medicaid). The Colorado Medicaid False Claims Act, 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 this state statute are subject to civil penalties of not less than $5,500 and not more than $11,000 plus three times the amount of damages the state sustains.

b. Colorado health care divisions

Colorado Department of Health Care Policy and Financing (HCPF)

HCPF has multiple programs and resources to combat fraud, waste, and abuse. The department's Audits and Compliance Division 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 and recovers inappropriate payments. A staff of nurse reviewers, claims reviewers, and data analysts are responsible for this work.

The Audits and Compliance Division also conducts preliminary investigations of suspected fraud and determines if there is a credible allegation of fraud. If a credible allegation of fraud is established, the issue is referred to the Colorado Medicaid Fraud Control Unit (MFCU), which is housed within the state's attorney general's office for a formal investigation and/or prosecution.
Several other sections within HCPF are also engaged in fraud prevention and detection:

- The 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;
- The Nursing Facility Section works to detect and reduce fraud, waste, and abuse associated with Medicaid Nursing Facilities in Colorado;
- The Audit Information Section works to reduce fraud, waste, and abuse committed by recipients of HCPF programs; and
- The Client Over-Utilization Program (COUP), also known as "Lock-In," 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 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 emergency room and

physician visits) in a three-month period might 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 and as required by federal law, HCPF has a recovery audit contract with Health Management Systems, Inc

Finally, HCPF participates in the Payment Error Rate Measurement (PERM) program developed by CMS to comply with the Improper Payments Information Act (IPIA) of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA and amended again in 2012 by the Improper Payments Elimination and Recovery Improvement Act or IPERIA). PERM audits Fee-for-Service and managed care Medicaid and Children's Health Insurance Program (CHIP) claims adjudicated in a fiscal year for improper payments and produces error rates for each program. For the next PERM audit cycle, CMS will also audit eligibility determinations for the Medicaid and CHIP programs.

Colorado Medicaid Fraud Control Unit (MFCU) - State of Colorado Office of the Attorney General

The MFCU is tasked with investigating and prosecuting cases of Health First Colorado provider fraud. MFCU's mission is to protect state and federal funds from fraud against Medicaid by individuals or companies that 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.

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 assisted living centers – regardless of whether the patient is a Health First Colorado client or not. The unit does not investigate abuse in the home or in non-Medicaid facilities. MFCU fraud jurisdiction covers all Health First Colorado providers.

The MFCU has authority to hold individuals or entities accountable through criminal prosecution and/or civil litigation. It 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.

While the MFCU investigates and prosecutes cases of provider and facility fraud, the Department of Health Care Policy and Financing (HCPF) has authority over individuals who receive services as part of the Health First Colorado program. Each county has a Department of Human Services which investigate suspected cases of recipient fraud, and the local district attorney's office prosecutes individuals who practice fraudulent schemes.

Colorado Department of Human Services (CDHS)

CDHS's jurisdiction encompasses inappropriate or fraudulent activity by all CDHS employees, CDHS management, CDHS appointees as well as community partners and subrecipients. The Department has the authority to examine all relevant records, financial statements, and client information, as well as to conduct interviews of those involved to complete investigations.

c. 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." The anti-fraud plan, which is required to be

submitted annually to the Colorado Department of Insurance (DOI), must outline 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 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 Department of Insurance (DOI) – Department of Regulatory Affairs

The DOI is authorized to conduct market examinations of commercial insurance carriers in Colorado according to Colorado statues and regulations. In 2017 legislation was passed that separated the financial exam statutes from the market conduct statutes and harmonized the various market conduct statutes. The revised market conduct statutes provide a more effective and efficient system for reviewing, evaluating and analyzing the activities, operations, and business affairs of the entities that transact the business of insurance in Colorado. The new market conduct statutes also enable the Insurance Commissioner to adopt a more flexible system of industry oversight that directs resources efficiently and effectively to administer and enforce the insurance laws of Colorado. Market conduct examiners, when possible, also utilize the NAIC Market Regulation Handbook and follow NAIC guidance when conducting market conduct 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 against companies for committing fraudulent activities. The attorney general has jurisdiction to prosecute insurance fraud throughout the state of Colorado. The DOI refers insurance fraud complaints it receives against consumers and agencies committing fraud against companies to the attorney general.

d. Guarding against new fraud and abuse exposures

As previously noted, the SIM Office relies on 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 (or something like it) in SIM practice contracts:

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)).

SIM will also ensure that payers participating in the model comply 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 Multi-Payer Collaborative (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. No financial information from participating payers will be shared with other payers or the general public during the discussion. During meetings and other activities, including all formal and informal discussions, each participant will refrain from discussing or exchanging information regarding any competitively sensitive topics. Such information includes, but is not limited to:

- Per-member per-month (PMPM);
- Shared savings; and
- Information about market share, profits, margins, costs, reimbursement levels, or methodologies for reimbursing providers, or terms of coverage.

e. 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.

The scope of the 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. As Colorado's health care delivery system moves toward more coordinated systems of care and accountable care organizations, 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 practices have made progress integrating physical and behavioral health in and have moved to value-based payment for primary care, there will be a basic infrastructure to create larger coordinated systems of care.

The SIM office recognizes that the introduction of new payment models will present opportunities for improved care and cost savings, and new forms of fraud and abuse. The 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 to gaming or abuse.

As the use of data is central to the implementation of value-based payments, the SIM office is working closely with OeHI to help ensure the safety, integrity and accuracy of data sharing and transfers within the state. SIM also works with payers, providers, CIVHC (APCD), Stratus™ and other data sources to ensure that data collected to support payment delivery models is accurate, complete and timely.

The SIM office created a new governance committee for HIT (outlined in the HIT plan) that will ensure the safety, integrity and accuracy of data sharing and transfers. It will also help the SIM team develop the

sustainability piece for this work in AY4.

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 identify potential opportunities for fraud and abuse and address any issues that arise during the Model Test as expeditiously and effectively as possible.

E. Sustainability plan

Since the start of the initiative, the SIM team has worked with stakeholders to ensure that the work is designed for long-term sustainability. Every program manager has plans for sustainability in his or her plan with vendors and SIM workgroups continue to help the team create, revise and propose ideas for sustainability of the work that has been initiated by and perpetuated with SIM funding through Colorado's commitment in the SIM proposal.
This section includes an outline of work done to date with sustainability planning as well as information that will be used to create Parts 1 and 2 of the sustainability plan. Included in the Colorado SIM AY4 workplan is a new sustainability work plan that will guide this work during AY4.

1. End-state vision

Colorado will encapsulate the end state vision of a transformed health care delivery system during the first half of AY4. The aligned approach to integrate behavioral health and primary care is foundational to this paradigm shift, which we are starting to see. Providers have improved efficiencies and designed care teams in which all providers work up to their licensure, streamline operational costs and optimize technology to improve patient care and reduce or avoid unnecessary costs. They can show their unique value (better health, lower costs) using data that shows how their approaches improve outcomes and reduce costs when working with health plans. Our communities are connecting to the health care delivery system to engage in population health efforts that better serve the needs of Coloradans.

2. Accomplishments to achieve state goals

The SIM team has approached its goal using all four pillars outlined in the original proposal. Ongoing progress across the spectrum of SIM enables a collaborative approach to health care reform that extends beyond the traditional health care clinic to enable future success. Examples that will be highlighted in our sustainability plan include:

1. Providing access to integrated physical and behavioral health services in coordinated community systems: SIM is working with about 330 primary care practice sites and four community mental health centers in three cohorts with an extended reach for health systems that participate in the initiative and share learnings with non-SIM practice sites within the systems.
2. Applying value-based payment structures: Six payers support SIM practices with different alternative payment models (APMs) and 81% of cohort-1 practices that responded to a SIM survey say that access to alternative payment models through SIM participation has helped them achieve their practice transformation goals.
3. Expanding information technology efforts: The SIM team has expanded broadband capability by 203 sites across the state and will continue to work on telehealth efforts in AY4.
4. Finalizing a statewide plan to improve population health: The SIM team has helped fund a new workforce in the form of regional health connectors and is funding local public health agencies and behavioral health transformation collaboratives (BHTCs) that touch 31 counties and continue to report meaningful success.

3. Setting us up for sustainability: Reflections from Colorado

As the SIM office develops a sustainability workplan for AY4, we have inventoried current achievements and necessary processes to ensure the sustainability of the year-four work. During this process, we catalogued some preliminary thoughts related to sustainability by driver below.

Practice Transformation

The practice transformation journey designed by the SIM team and the University of Colorado Department of Family Medicine (UCDFM) and vetted by stakeholders helps SIM practices integrate behavioral and physical health and prepare for success with alternative payment models (APMs) that reward the value versus volume of care delivered. The three SIM cohorts that progress along the integration pathway gain knowledge, skills and tools that enable them to deliver evidence-based, whole-person care, and to collect, report and use data that proves their unique value to health plans. Practice transformation support (coaching funded by SIM) helps build and empower quality improvement teams to assess processes for efficiency and ensure a team-based approach that helps all team members work up to licensure. These teams also learn how to improve data collection to improve their ability to manage patient populations in ways that improve health and avoid or reduce unnecessary costs. There is proof that this approach is working. One SIM cohort-1 practice physician recently said the skills his practice team gained in SIM helped the practice qualify for tiered risk models from a local health plan.

The knowledge gained during this process will empower practice quality improvement teams to continue their work after SIM funding ends in July 2019. This was part of the original sustainability plan — that coaches would take a train-the-trainer approach, which ensures that skills learned will continue to be tapped by care team members, who are able to lead their work practice transformation work in the future.

In addition to the continuous quality improvement aspect of SIM, practice teams learn the value of communicating the work they do to improve patient outcomes to health plan representatives. The SIM team encourages this type of approach through outreach to SIM practices with requests for them to present the work they've done during the initiative during Multi-Stakeholder Symposiums to build better relationships between payers and providers.

In AY4, the SIM team will continue to request presentations from SIM providers, who explain their work and data that shows how it benefits patients and effects costs, which helps narrow the gap between perspectives on what it takes to integrate care and why health plans should help sustain this care delivery approach with alternative payment models. Efforts will continue to engage the self-insured employer market to engage all payers in the state.

4. Sustainability: SIM pillars

a. Payment reform

Members of the Multi-Payer Collaborative (MPC) identified behavioral health integration as a priority for the collaborative through their work with SIM. Payers, both public and private, will continue to participate in the MPC after the SIM initiative ends to maintain progress made under the Comprehensive Primary Care Plus (CPC+) initiative. SIM is expected to demonstrate value to payers, which will lead them to extend alternative payment models (APMs) to new practices or to develop new payment models that are focused on behavioral health integration. In this manner, the SIM initiative is building a foundation for sustainable, ongoing financing to support transformation of the healthcare delivery system. Details about the payers' return-on-investment analyses are expected in AY4. SIM will continue to play a role in the MPC through the final grant year of the initiative. For more information on the continuation of the MPC beyond SIM, see the program monitoring and reporting section.

The SIM office acts as liaison between payers and practices and has encouraged payers to provide greater clarity and frequency of practice communications regarding APMs. The SIM initiative affords payers a significant amount of flexibility in how they design and adapt their payment models. By allowing payers the flexibility to adjust their payment models between cohorts, payers can adapt to changes in the market. There has been frustration about the lack of one, streamlined "SIM-specific" payment model, yet the focus on enhancing provider skill sets to negotiate differently might prove more valuable than one set APM that would end with the initiative. The focus for SIM practices has been on building a skill set for data collection, reporting and use that becomes institutional knowledge and will help practices build different relationships with payers, and improve their ability to negotiate contracts that help them sustain the work they have started.

From a payer perspective, the flexibility to adjust support in response to the evolving landscape has contributed to the retention of payers in the initiative and created an opportunity for payers to test their own models. Payers plan to use lessons learned through SIM to inform future support for practices and sustain progress toward promoting greater integration of behavioral healthcare.

The SIM team will continue to be actively involved in the Health First Colorado (Medicaid) Accountable Care Collaborative Phase II rollout in AY4 and will engage with the new regional accountable entities to ensure that they understand the work that SIM practices are doing. Due to the work that SIM practices are required to do with clinical quality measure reporting, they have a "glidepath" to the new APM that Medicaid introduced, which underscores the value of aligned measures and the guidance SIM practices receive from practice coaches.

The team is also investigating a "measure library" to view measure alignment with "volumes" of measures identified in core clinical domains that each payer would agree to use. The possibility of a measure library has been of interest to members of the MPC because it would lessen the burden of practice reporting and set a consistent standard statewide for reporting progress in the quality and value of patient care.

The SIM office has aligned with the priorities of the Quality Payment Program (QPP) and several other initiatives to align the measures that practices have to report. The revised SIM Framework and Milestones (referenced in the health care delivery system transformation plan and included as ***Appendix F4***) was designed to help practices build the necessary competencies to succeed with the QPP. In defining and prioritizing the framework's practice transformation activities, the SIM office created a crosswalk of expectations under Medicare Access and CHIP Reauthorization Act MACRA with the original set of SIM practice transformation milestones used for cohort 1 and adjusted milestones to ensure that SIM practices were focused on activities that would prepare them for QPP. These intentional efforts to complement expectations for MACRA allowed the SIM office to frame participation in SIM cohort 2 and cohort 3 as an opportunity to prepare for success with QPP. The RFA for cohort 2 and cohort 3 contained the following language:

> Participation in SIM helps providers prepare for a changing healthcare landscape that has been shaped by MACRA, a bipartisan piece of legislation signed in 2015 designed to pay providers for the quality and effectiveness of the care they provide Medicare beneficiaries. Other payers have also implemented value-based payment models. This shift from volume-based to value-based payment puts the onus on practices to demonstrate higher-quality care that improves outcomes while reducing costs. Success in this value-based reimbursement world requires different skills and processes that allow providers to integrate behavioral health and primary care. The SIM Initiative helps guide practice sites along this path with intensive coaching to implement integrated care and turn data into actionable information that helps build sustainable models.

These efforts help focus SIM practice efforts on successful participation in SIM and on identifying and pursuing a long-term strategy for sustaining success within an evolving healthcare landscape. SIM was also one of the founding members of the Colorado Quality Payment Program Coalition (http://www.cms.org/communications/colorado-qpp-coalition)/ SIM will continue to play a role in in the QPP Coalition through the final grant year and disseminate pertinent resources to participating practices in AY4.

b. Population Health

The plan for improving population health outlines work undertaken by the Colorado Department of Public Health and Environment (CDPHE) to identify partners that will sustain work started with SIM initiative and address gaps in behavioral health efforts. This work will inform SIM's strategy for sustaining population health improvement activities beyond the initiative's funding.

The population health workgroup published its call-to-action report (appendix y) in May, which will continue to drive work for the next 14 months. The report also charts successes for the next five or 10 years, which aligns with the governor's dashboard, state agency work and more. It's a way to bring partners together in ways that will drive the population health conversation during the next 10 years. It also includes key activities and recommendations for positive population health change movement. Each stakeholder should be able to take this call-to-action and use it to design future work and align with other agencies. The goal is to build community-clinical linkages outside the clinic walls, which will lead to transformational change in Colorado. Stakeholders agree that the report will prompt more people to think about influencing health from a broad, whole-person perspective.

The use of advisory and steering committees across SIM-funded LPHAs is an integral element to sustainability of the funded population health activities. By building capacity to understand and respond more effectively across agencies in a community, the LPHAs are setting their communities up for success to take up the mantle of this type of work when the funding for SIM is completed, and they may have to take a step back from leading this charge. LPHAs (SIM-funded and non-SIM-funded) are identified as key implementers within the call-to-action report. Each of the 12 recommendations have sample activities identified where LPHAs can champion early, medium and long-term wins for positively shifting health outcomes for the populations they serve, which will in turn shift health outcomes for the population of Colorado. The co-chairs of population health workgroup are instrumental in ensuring LPHA local plans encompass recommendations from the call-to-action report.

The amount of coordination and networking occurring between SIM-funded agencies is building capacity among these agencies to form connections with other local subject matter experts across the state, as seen in the level of coordination with expanding Let's Talk Colorado. These relationships will continue to form and strengthen in the remaining time of the initiative and will allow agencies to leverage those relationships even after the grant period concludes.

The work completed has already led to discussions about how different communities will fund the work once SIM ends in July 2019, as outlined in the Population Health Work – BHTCs section of this report. For example, work in Aurora Public Schools (APS) has been successful to the point that APS will adopt a curriculum for universal implementation of prevention education for the 2018-2019 school year. This adoption will occur in AY4, which allows APS to lead the charge for its students once SIM funding ends. In AY4, the SIM team will work with its partners at the Colorado Department of Public Health and Environment (CDPHE) to learn more about what prompted this independent investigation into sustainable funding in the hopes of replicating it — as appropriate.

SIM-funded LPHAs continue to consider and plan for sustainability of their activities. Key practices important to this effort are working to align their activities with other programs funded by a different grant or funding stream. For example, Northeast Colorado Health Department has been using and promoting Man Therapy, a program out of CDPHE's Violence/Injury Prevention and Mental Health Promotion (VIP-MHP) branch, as well as the PRD awareness campaign, which was created by the Children, Youth, and Families Branch at CDPHE. This allows them to potentially use such materials in similar efforts even after SIM funding ends.

Colorado's strategic behavioral health population health roadmap (plan for improving population health) is another example of how SIM-funded activities include state agencies and other groups that will outlive the initiative, so the work will continue. It illustrates the work to improve the behavioral health and wellness of the population. Given that behavioral health affects the overall health of the population, our roadmap represents an inventory of behavioral health strategies that align with advancing SIM goals and represents opportunities to support Colorado's health delivery system and behavioral health integration efforts.

The RHC Program is a collaboration between several initiatives and organizations: SIM, ENSW, the Colorado SIM Office, the University of Colorado Department of Family Medicine, the Colorado Health Institute, Trailhead Institute and 21 RHC host organizations across the state (not to mention myriad stakeholders working with each RHC). No single organization has authority over the entire program; therefore, a sustainability group that represents the initial funders, RHCs, host organizations, and other stakeholders will be convened to make decisions about the future of this collaboration. SIM team members and CMMI representatives will join the RHC team for a sustainability discussion during the CMMI site visit in May.

The RHC Sustainability Group shall consist of nine members who represent key stakeholders engaged in the Colorado RHC Program:

- Five members will represent the RHCs and RHC Host Organizations, with a mix of organizational types and geographies that reflect the diversity of these stakeholders.
- Two members will represent the original two funders, with one delegate from ENSW and one delegate from SIM.
- Two members will represent the clinical partners engaged in this program, with a mix of front-line health care provider and health systems administrator experience.

RHC program staff will drive the decision-making process and implement the decisions of the RHC sustainability group but will not be considered members of the group.

The RHC Sustainability Group plans to address each of the following high-level questions by fall 2018:

- What support functions are needed to sustain the Colorado RHC Program after July 2019?
- What is the appropriate governance structure for the Colorado RHC Program after July 2019?
- What improvements should be made to the Colorado RHC Program design after July 2019?
- Which organization will fund the Colorado RHC Program after July 2019?

In AY4, the SIM office will continue to support implementation of the RHC program by joining the RHC Sustainability Group and overseeing the final year of funding for the program. The SIM office will continue to work with the population health workgroup to provide guidance on implementation and sustainability.

The braided funding structure used to finance the regional health connector (RHC) program (detailed in

the plan for improving population health) was pursued to ensure the short-term sustainability of the program, as EvidenceNOW Southwest (ENSW) funds were scheduled to end before SIM. Braiding the funds extended the term of RHCs. Looking toward long-term sustainability, RHC program staff have convened a technical advisory group (TAG) to provide feedback and advice on development and delivery of the RHC program after SIM funding ends. The TAG provides guidance on communication, sustainability, governance and leadership. In AY4, SIM program staff will work with the TAG to develop a sustainability plan.

c. Health Information Technology

SIM's HIT strategy is focused on expanding infrastructure that will benefit SIM practices and enhance functionality after the initiative ends. It has always been intended to be a long-term investment for Colorado providers. The HIT section outlines the SIM strategy for ongoing infrastructure expansion and the program monitoring and reporting section details how the SIM office is working with HCPF's Health Information Office to ensure sustainability of operations.

The electronic clinical quality measurement solution (outlined in the HIT section) represents a sustainability plan for much of the practice transformation work, which is proven to health plans through reporting. However, reporting these measures has been cited as a common barrier by SIM practices, which is one reason the team sees the new eCQM solution, which will be rolled out in AY4, as a piece of the sustainability plan. The ability for practices to have data extracted from their electronic health record systems once and reported to different, approved entities reduced provider burden and improves a practice's ability to succeed with APMs.

Sustainability has been a consistent driver in the design of SIM's eConsult strategy, which is outlined in the HIT section. Telehealth models have demonstrated mixed outcomes across the country, making sustainability planning even more important to the success of this program. SIM identified a strong link between sustainability and payers' long-term vision and strategy for telehealth and eConsult services. SIM partnered with HCPF to design a model that closely aligns with Medicaid initiatives in this domain, and work in AY4 will include negotiations with the new regional accountable entities. Systems/RAEs will conclude with a final report at the end of the year measuring overall progress against the original baseline. SIM will use the findings to evaluate funding impact.

Ownership of the Shared Practice Learning and Improvement Tool (SPLIT) resides with SIM though further development continues in partnership with UCDFM. After SIM's conclusion, ownership of the tool will shift to UCDFM and that team will be responsible for maintenance and future development costs associated with it. There have been discussions about development activities after SIM and potential funding sources for this work.

SPLIT has the potential benefit of helping practices as they invest in practice transformation work. Practice representatives will be able to look at notes and CQMs longitudinally to better manage their patient populations. For SPLIT to realize its full potential, development tasks need to be fully completed which will result in an automated process between the practices and SPLIT. The SIM office will ensure further development during AY4. Some examples of monitoring tools that SIM has implemented to ensure completion of SPLIT's development include assigning a project manager from the Colorado Department of Health Care and Policy's Office of Information Technology to concurrently monitor and supervise the activities of the eCQM solution and completion of SPLIT, closer review and regular monitoring of the UCDFM's scope of work, regular progress updates and more specific deliverable requirements.

The team continues to explore sustainability options for the Stratus™ tool with payers and providers. Efforts have been focused on provider activation of licenses and use of the tool, which provide examples of success to share with other practices. The goal—to help providers access and use claims data from

different payers in one location—has taken time to realize, due to operational constraints, which the team continues to address. All cohorts will have access to this data aggregation tool including continued access for cohort 1 practices after their active participation in SIM is over. The tool helps SIM practices assess utilization and costs and compare themselves with groups in their specialties and regions. SIM practices receive access to several data tools (comparison of these tools, Appendix B1) helps practices identify opportunities for improvement as well as a unique value that they can communicate with health plans. More detail will be included in the sustainability plan.

c. Evaluation

The SIM initiative was designed to allow for adaptations and rapid-cycle improvements based on lessons learned. Recruiting SIM practices in three discrete cohorts has allowed program staff to make changes based on feedback collected via practice surveys, TriWest rapid cycle feedback reports and conversations with key stakeholders. Between cohorts 1 and 2, the SIM office revised its practice transformation building blocks, streamlined its clinical quality measures, changed the structure of grants and achievement-based payments and laid the foundation for increasing its health information technology (HIT) support (a table detailing changes made to the cohort-2 model is provided in the health care service delivery section). Evaluation of SIM will continue in various forms beyond the life of the initiative. TriWest was contracted to plan and identify the structure of this in AY3 and a report is included in ***Appendix L3***. It addresses all the sustainable evaluation activities by sections corresponding to each of the primary SIM drivers. For each driver, it poses questions and suggests possibilities around intended continuation and sustainability of activities, structures, data sources and outcomes. This report will be updated in AY4, which will account for changes that were made to the evaluation research questions in AY3. The SIM team will work with TriWest to align its recommendations with the sustainability plan submitted to CMMI in AY4.

In summary, Colorado SIM is well poised to accomplish the milestones developed in the sustainability work plan and deliver a sustainability plan that is the culmination of input and guidance from informed leaders and stakeholders, who have supported the SIM initiative since the beginning. The momentum continues and there is a dedication across the state to ensure our investment in the foundational transformation of our delivery systems continue to transform care delivery in Colorado and improve patient health.

F. Operational plan appendices

To download the appendices to the operational plan, enter this link into your web browser:
https://drive.google.com/file/d/1hEiI9-NnXhEEIfnfC_WRLW4cUjZJ82Om/view?usp=sharing