Colorado State Innovation Model Evaluation

Colorado SIM
Office

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Executive Summary

This report describes the work Community Mental Health Centers (CMHCs) have done towards practice transformation, assesses progress CMHCs have made in their first full year[1] of implementation, and discusses successes and challenges in order to highlight "best practices" or reveal common implementation challenges that could be improved through strategic technical assistance.

As outlined in the State Innovation Model (SIM) Operational Plan, Colorado SIM has two main efforts to improve access to integrated physical and behavioral health services in Colorado: the primary care effort and the Bi-Directional Integration Health Homes. The first, the primary care effort, will seek to recruit 400 primary care practice sites to participate in practice transformation efforts over the course of the SIM initiative. These primary care practice sites will aim to integrate behavioral health care into their sites through assistance from the SIM office—and Practice Transformation Organizations (PTOs)—under guidance by the University of Colorado, Department of Family Medicine (UCDFM). This includes support in the form of access to the Shared Practice Learning Improvement Tool (SPLIT).

The second effort, the Bi-Directional Integration Health Homes, will create integrated health homes in 4 of the 17 CMHCs in Colorado. These CMHCs are the Community Reach Center, the Jefferson Center for Mental Health, Mental Health Partners, and the Southeast Health Group. Bi-directional integration focuses on the joining of primary care and prevention services into a community behavioral health setting. Because CMHCs serve as the primary locus of care for many Coloradans—particularly those managing a serious mental illness (SMI) or addiction—the CMHC representatives believe that the integrated health home represents the best opportunity for the greatest cost reduction for individuals with the greatest needs and highest costs of care. Under the strategic leadership of Colorado Behavioral Health Council (CBHC) and the Colorado SIM office, these sites are working to create alignment within the broader Colorado SIM initiative, and, like the primary care practice sites, they will gather and report integration progress through the Shared Practice Learning Improvement Tool (SPLIT), will gather health outcome and quality data, and will receive cost and payment data from the All Payer Claims Database (APCD).

The four CMHCs and the primary care sites receive assistance from the SIM office and PTO Practice Facilitators (PFs) and Clinical Health Information Technology Advisors

(CHITAs). PFs and CHITAs will assist practice sites and CMHCs to meet practice milestones and develop practice

[1] There was an initial delay in CMHC funding from February to November 2016. Sites were officially provided with funding in November of 2016, but many had already done some SIM integration work prior to the official start date.

improvement plans that help them move towards greater integration of behavioral and physical health care in primary care sites and CMHC health home sites.

Descriptions of the four CMHCs are provided in the body of the report, beginning on page 12. These descriptions present information about the approaches the CMHCs are using to integrate care, such as working with Federally Qualified Health Centers (FQHCs) for physical health care or hiring their own primary care provider. Though three of the four centers focus primarily on people with serious mental illness (SMI), they also serve people with broad ranges of need, depending on the specifics of each center. All centers focus on a whole-person, team-based approach and stress the need to include integrated care.

The descriptions note the successes the CMHCs have experienced with building an integrated approach, especially those centers focused on the work being done with FQHCs to integrate primary care. They also describe the challenges of replacing departing staff and maintaining a team environment when teams are incompletely staffed. Surprisingly, those challenges have resulted in some positives reported by the centers as new members have presented opportunities to build support or to improve approaches to integrated care. Examples include bringing new leadership up to speed on the SIM initiative and finding a behavioral health provider that was willing to become credentialed as a Certified Addiction Counselor

Each of the four CMHCs submitted 2–3 “Success Stories,” highlighting significant steps in addressing the building blocks of practice transformation. These stories are presented in green breakout boxes throughout the report.

In addition to these successes and challenges, the CMHCs were affected by funding

delays. These delays were the result of CMHCs being unable to fund clinical positions that were part of their original implementation plans, causing the centers to have to find other mechanisms for funding those positions or to adjust their models to reflect the loss of those clinical positions. While this delay was a significant challenge for the CMHCs, there were some benefits around the assessment process and data collection reported by the SIM office. For example, CMHCs may have potentially benefited from learning from cohort 1 experiences regarding assessments and reporting, including the more streamlined building blocks and the changes to CQM reporting. CMHCs were also positioned to gain from changes in the approach to assessing practice milestones that resulted from the revision of the Milestone Activity Inventory into the Milestone Attestation Checklist (MAC). That change may allow CMHCs to benefit from the efforts by payers to prioritize building blocks for refined payment reform efforts. However, because the payment models differ vastly between CMHCs and primary care practice sites, the degree to which the payment reform learnings can directly translate to the CMHCs' work towards sustainability is unclear.

Throughout this report, some comparisons are made to the primary care practice sites participating in cohort 1. Although these comparisons may be helpful, some caution is appropriate: both the approaches of the CMHCs and the populations they target differ significantly from most of the primary care practice sites. In addition, there are only 4 funded CMHCs, compared with 92 primary care practice sites participating in cohort 1. However, understanding both the similarities and differences in the approaches may be helpful in identifying best practices useful to all of the centers.

Practice Transformation Efforts

Practice transformation data come from a series of assessments collected in the Shared Practice Learning Tool (SPLIT), which is used by both primary care practice site cohorts and the CMHCs. These tools are described further in the body of the full report. The four CMHCs were assessed by the Integrated Practice Assessment Tool (IPAT),[2] which uses a decision-tree model to place practice sites into discrete collaboration/integration categories.

At baseline, CMHCs were at IPAT level 4 (co-located) or level 5 (integrated). These

levels differed from the variability of cohort 1 SIM practice sites—a much larger and more diverse group (n=92). At baseline, 27.2% of the practice sites were at the "co-located" level of integration, and 30.4% were at the level of "integrated." As detailed later in the report, the CMHCs all had experience with integrated care prior to SIM and would reasonably be expected to reach higher levels of integration. Cohort 1 practice sites demonstrated change in the number and percentage that moved into level 4 (co-located) or higher one year after baseline. However, much of that change involved practices at level 3 or lower moving to level 4 or higher. Since all CMHCs started at level 4 or 5, a question remains about whether CMHCs will show significantly more integration in follow-up assessments, at least as measured by the IPAT.

Success Story Jefferson Center screens mothers with the Edinburgh Postnatal Depression Scale and has now expanded depression screening to include other caregivers associated with the new baby. These caregivers are screening using the PHQ9, and then successfully connected to a continuum of services when appropriate. New fathers have been a key target audience and have been receptive, though in some cases surprised, to see their own mental health as a consideration after the baby is born.

[2] Waxmonsky, J., Auxier, A., Wise-Romero, P., & Heath, B. Integrated Practice Assessment Tool (IPAT). Available at https://www.integration.samhsa.gov/operations-administration/IPAT_v_2.0_FINAL.pdf. Additional information is available at the SIM resource hub: http://resourcehub.practiceinnovationco.org/2017/02/03/ipat/

The Milestone Activity Inventory (MAI) provides a way for practice sites to record specific transformation activities that have been implemented. These activities make up the "building blocks" for practice transformation. The Medical Home Practice Monitor[3] provides ratings of overall completeness of building block implementation, including the Behavioral Health Integration Building Block (#11).

Both of these assessments show that CMHCs have made progress in their practice transformation efforts and, more specifically, behavioral health integration. On average, CMHCs moved from implementing 56.3% of maximum possible milestone activities completed to 65.4% completeness.

CMHCs also improved on the activities specifically associated with the Primary-Behavioral Health Integration building block (#11). This building block was revised to better align with CMHC activities (which differ significantly from primary care practice sites' activities). This building block specifically outlines from 57.7% completeness of implementation (at the intended start date) to 71.2% at baseline. Compared to the 61.0% baseline level of cohort 1 practice sites, this 71.2% indicates a greater degree of completeness of the behavioral health integration building block implementation for the CMHCs. Although the goal for all SIM practice sites is improved percentages of completeness in the building blocks, neither primary care practice sites nor CMHCs are expected to reach 100% of completeness, as each will move through those building blocks via slightly different paths to integration.

Success Story Southeast Health Group is the only CMHC site testing an "in-house" primary care model, hiring primary care providers as employees of the agencies rather than pulling from an outside organization. With their Practice Facilitator, SHG has taken on significant technical assistance to improve primary care delivery and improve billing practices. They have worked with a Certified Medical Coder who has provided great insight into the primary care billing model, payer relationships, and rates.

Practice Facilitators (PFs) and Clinical Health Information Technology Advisers (CHITAs) will assist practice sites and CMHCs to implement practice milestones and practice improvement plans that move towards greater integration of behavioral health care and primary care. These milestones all make up the 10 building blocks for integration, plus an additional "Behavioral Health Integration" building block. Overall milestone establishment by CMHCs at baseline (69.5%) was comparable to the 69.1% baseline level for cohort 1 sites. The pattern was similar

[3] The CMHCs are using a slightly modified version of the Monitor. It was revised to better reflect the CMHC setting at the beginning of the project: "Comprehensive Primary Care Practice Monitor Mental Health Center Version 2- 22-16" .

in some ways with both groups having higher completion rates for the foundational building blocks 1 through 4. CMHCs tended to have higher completion rates for building

block 1, Engaged Leadership. CMHCs averaged 93.8% of milestones completed or established compared with 71.2% for cohort 1 practice sites. Building blocks 5 through 10 were more similar, but cohort 1 practice sites averaged higher completion for building block 7, Continuity of Care, and for building block 9, Care Coordination.

Success Story Building deep partnership and collaboration with patients is an essential Building Block (#5) effort for practice transformation. At the end of Year 2, with the support of its Practice Facilitator, Community Reach Center (CRC) formed two Patient Advisory Councils: one for English-speaking patients and one for Spanish-speaking patients. With these groups in place, CRC is actively developing and implementing decision aids, self-management support tools, and protocols for strengthening patients' roles in their own care. The groups have empowered consumers to see themselves as a driving force in the health home and their own care.

CMHCs changed to the revised milestone assessment instrument for their first bi-annual follow- up reassessment in November 2017. The revised instrument, the Milestone Attestation Checklist (MAC), was used in this report to assess the overall degree to which centers are implementing milestones through completion of activities. The overall average building block percentage of completion was computed and is presented for comparison to the baseline score of 69.5%. The average score for the November 2017 MAC assessment was 78.2%, reflecting what is most likely improvement in establishing milestones necessary for integrated care.

Practice Improvement Plan (PIP) goals chosen by CMHCs were similar to those chosen by cohort 1 practice sites with a focus on building block 6, Population Management, but they did not share the extent of the cohort 1 focus on building block 2, Data-Driven Improvement.

Finally, about 81% of practice site staff and clinicians surveyed by UCDFM indicated agreement or strong agreement that they were satisfied with their work.

Health Information Technology Efforts

Each CMHC has completed a baseline Data Quality Assessment and a follow-up revised Health Information Technology Assessment. These assessments focus on sites' abilities to report on Clinical Quality Measures (CQMs), HIE connectivity, and telehealth capabilities. The assessments also include notes from the Clinical Health Information Technology Advisor (CHITA) working with the centers.

While these elements are all important components of the overall SIM effort, they apply to CMHCs in different ways. For example, although three of the four CMHCs report telehealth capabilities, telehealth is not a significant component of their team-based care models.

Success Story The Boulder Integrated Health Home identified patients with diabetes or pre-diabetes who also have a serious mental illness as a key focal point for their clinical care team to address with their SIM Practice Facilitator. Together, they have established a common protocol to best meet this population's needs. They have also established a menu of evidence-based supports that can be tailored to meet individual patient needs. These services include medical support, nutrition and health coaching, and group treatment services. The health home team monitors the impact of these services and broader educational activities on hemoglobin A1c levels and solicits feedback from the patients engaged in this care. Group engagement has been very high, and feedback has been immensely positive to date.

As was the case with the cohort 1 primary care practice sites, the vast majority of technical assistance activities for the CMHCs during their first year centered around reporting on CQMs, as revealed by CHITA-filed notes.

As noted, none of the centers are focusing on telehealth as a primary method of integrating care. However, three of the four centers do have telehealth capabilities. Of those three, two use telehealth to provide psychiatric services; the third uses telehealth for some psychological counseling services.

Two of the CMHCs report current Health Information Exchange (HIE) connectivity, but field notes do not elaborate on the degree to which these have been useful in current integration or data reporting capabilities.

The four CMHCs all began with high Data Quality Assessment scores (DQAs),[4] leaving a small window for improvement. Their confidence and ability to report on both important individual data elements as well as to compile and report on CQMs stayed about the same between baseline and the six-month (January 2018) follow up.

All CMHCs noted difficulty reporting on two of the three substance use disorders (SUD) measures. One site is focused on a pediatric population, which is not appropriate for these measures. Two of the sites stated concerns that the number of SUD patients receiving treatment is undercounted as a result of (1) complexities with patient flow between behavioral

[4] The Data Quality Assessment (DQA) is completed by the CMHCs with assistance from their CHITA at six-month intervals. The DQA is described in greater detail in the body of the full report.

health and physical health providers (depending on which provider is seen first) and (2) payment issues, depending on how services are billed. One CMHC had higher rates of treatment on these two measures and reported more confidence in its data. That CMHC reported less of an issue because the behavioral and physical treatment occur in the same site location. The other three sites may benefit from support on how to best report the substance use disorders CQMs.

Client Outcomes

Currently, baseline data are available for client outcomes, as measured by the Colorado Client Assessment Record (CCAR), Heath-Related Quality of Life Indicators, and CQMs. These data will be monitored over time for future reporting.

Across primary care practice sites and the CMHCs, there is greater confidence in CQM measures reported during the fourth quarter of any given year, according to direct practice site and SIM office comments made when measures are submitted. For that reason, the SIM office will be using Q4 2017 as “baseline” and for setting targets for the CMHCs. However, a trend analysis that includes CQM reporting for earlier time periods indicates that the CMHCs may have demonstrated some improvement in these measures since their actual implementation start in early 2017.

We recommend that target setting should take this into account and that future analyses of change over time should also consider that the baseline measure may be somewhat artificially inflated. For the evaluation, using high baseline scores mean

there is little room for the centers to show statistically significant improvement as a result of SIM.

Recommendations

The SIM office has seen the benefits of lessons learned and has recognized the importance of providing technical assistance to practice sites and the CMHCs. That technical assistance has been critical to enabling progress in building the capacity for integrated physical and behavioral health care in primary care settings. The progress already made by the CMHCs in completing the building blocks for integration shows that they have benefited from technical assistance and, as discussed below, some of the emerging insights from the initiative, once more fully realized, will provide some lessons that will in turn benefit the larger SIM effort.

- One recommendation based on these preliminary data is that the SIM office work with PTOs and CHITAs for the CMHCs to problem-solve how to improve reporting on the SUD treatment measures. In this area, collaborative problem solving across the centers may be beneficial. Because the SIM office allows for alternative methodologies for computing some CQMs (if necessary), there may be benefit to CHITAs working to find a method that works for the unique situations of the CMHCs so that these important measures can be tracked over time in the same way across the four centers. It is worth exploring whether alternative numerator and denominator specifications could help address the unique nature of CMHC structure and populations served. Workflows might also be examined to isolate any (if they exist) issues around recording SUD screenings and treatment in EHRs.

- Across primary care practice sites and the CMHCs, confidence in the accuracy of Q4 reporting of the CQMs is higher than in other quarters. For that reason, the SIM office will be using Q4 2017 as “baseline” and for setting targets for the CMHCs. However, a trend analysis that includes CQM reporting for earlier time periods indicates that the CMHCs may have demonstrated some

improvement in these measures since their actual implementation start. We recommend that target setting should take this into account and that future analyses of change over time should also consider that the baseline measure may be somewhat artificially inflated.

- As mentioned, previously, there are also some emerging insights across each of the four centers that, once more fully tested and described, might provide very helpful examples of “best practices” that may inform not only the other SIM-funded centers but also other CMHCs across the state and some of the primary care practice sites.

- The data warehouse being used by two of the CMHCs for shared care planning

  represents an example of creative problem solving to address the common issue of differing EHRs that cannot transmit patient data between them. This model could be a successful solution for primary care practice sites that (1) are working on integration strategies besides co-location and (2) will need to develop shared care plans with external mental health providers. The project is in its early stages but if successful will yield important lessons.

- The Jefferson Center for Mental Health appears to be having some success engaging

  new fathers in depression screening. This experience may be informative, particularly as the SIM office begins to more broadly share the Call to Action that includes a focus on male depression. The Jefferson Center may soon be in a position to share in more detail the specific strategies it found successful in conducting depression screening with this important and specific population of men.

- Mental Health Partners has implemented an in-house psychiatric consultation model to solve the problem of difficulty in scheduling psychiatric appointments. It is unclear whether this model could be useful for primary care practice sites that are struggling to hire behavioral health providers. However, it could be informative for other CMHCs with interest in integrating primary health care.

- Many practice sites struggle with billing for behavioral health services. As

part of

Southeast Health Group's response to struggles with primary care billing, it has brought in a medical coding specialist. If this approach proves helpful, the SIM office and PTOs may consider exploring whether enlisting the assistance of behavioral health service coding specialists, perhaps with guidance from the Colorado Department of Health Care Policy and Finance (HCPF), specifically around the new Regional Accountable Entity (RAE) structure, could assist primary care practice sites as they work on sustainability of their integration efforts.

Introduction

This report describes the work Community Mental Health Centers (CMHCs) have done towards practice transformation, assesses progress CMHCs have made in their first

full year[5] of implementation, and discusses successes and challenges in order to highlight “best practices” or reveal common implementation challenges that could be improved through strategic technical assistance.

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CMHC Descriptions

As outlined in the State Innovation Model (SIM) Operational Plan, Colorado SIM has two main efforts to improve access to integrated physical and behavioral health services in Colorado: the primary care effort and the Bi-Directional Integration Health Homes. The first, the primary care effort, will seek to recruit 400 primary care practice sites to participate in practice transformation efforts over the course of the SIM initiative. These primary care practice sites will aim to integrate behavioral health care into their sites through assistance from the SIM office, and Practice Transformation Organizations (PTOs), under guidance by the University of Colorado, Department of Family Medicine (UCDFM). This includes support in the form of access to the Shared Practice Learning Improvement Tool (SPLIT).

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the strategic leadership of Colorado Behavioral Healthcare Council (CBHC),[6] these sites are working to create alignment within the broader Colorado SIM initiative, and, like the primary care practice sites, they will gather and report integration progress through the Shared Practice Learning Improvement Tool (SPLIT), will gather health outcome and quality data, and will receive cost and payment data from the APCD.

The four CMHCs and the primary care sites receive assistance from the SIM office and Practice Transformation Organizations (PTOs) that manage Practice Facilitators (PFs) and Clinical Health Information Technology Advisors (CHITAs). PFs and CHITAs will assist practice sites and CMHCs to implement practice milestones and practice improvement plans that move towards greater integration of behavioral and physical health care in primary care settings.

Practice sites and CMHCs have committed to reporting data from a range of assessments to monitor their progress and to report a set of clinical quality measures (CQMs) to build practice data capacity. CBHC receives funding from SIM to provide leadership and oversight for practice transformation activities undertaken by the CMHCs. In addition, CBHC will link the CMHCs to various SIM opportunities for provider education, convene bi-annual learning collaboratives, and offer technical assistance through PTOs. These activities aim to support CMHC progress. In addition, as they do with the SIM cohort primary practice sites, the PTOs provide each CMHC with a PF to support general transformation work and a CHITA to support practice technology needs.

Since this report focuses on the CMHCs, brief overviews of each center's approach are provided below. These overviews were written and provided by the individual CMHCs and reflect their own views of the work they are doing. They include program descriptions and also highlight select successes and challenges. All CMHCs have previous experience with providing integrated care. SIM provides the opportunity to continue to improve, expand, and enhance the integrated care these centers provide.

Community Reach Center

Community Reach Center (CRC)—a private, nonprofit CMHC—is one of the premier integrated health providers in the north Denver area. For the Bi-Directional Integration Health Homes, CRC is partnering with Salud Family Health Centers, a Federally Qualified Health Center serving communities in northeastern Colorado. CRC and Salud have a strong history of collaboration

[6] CBHC is the membership organization for Colorado's network of community behavioral health providers. With funding from CMMI and in partnership with the Colorado SIM office, CBHC facilitates and manages the SIM Bi- Directional Pilot Program with these four CMHC pilot sites.

and offer a highly developed system of integrated care. In December 2014, the partners collaborated to place a medical clinic within the CRC Commerce City Outpatient Clinic. The SIM funding is transforming this clinic into a fully integrated health home.

During the two fiscal years prior to SIM, approximately 60% of patients in the Commerce City Outpatient Clinic had serious mental illness (SMI). Only 35% of patients reported having a primary care physician, and about 43% reported household incomes below poverty level. Consumers with a variety of payment sources are served including those with Medicaid, Medicare, commercial insurance, and private pay. Most CRC patients have Medicaid.

This project focuses on serving individuals in the Commerce City community with serious and persistent mental illness (SPMI). Those individuals are a subset of people with SMI, specifically people who often have significant mental and physical health issues that are difficult to treat separately from one another and that, if left untreated, lead to significantly shorter lifespans compared with the general population. Integrating treatment provides better health outcomes for patients, resulting in consumer financial savings and an improved experience of care.

Consumers can present to the Integrated Health Home via walk-in or referral from the community or CRC or Salud. The CRC front desk staff collect pre-intake information and triage to the most appropriate medical or mental health service. Intakes and assessments are completed. Additional services are provided as needed. Treatment

plans are developed collaboratively, and care coordination is done with the consumer with necessary subsequent appointments and follow up.

The CRC SIM initiative's aim is to understand the SPMI population and address the best ways to target interventions for that population's needs. The Integrated Health Home will determine its true cost of providing integrated care while also working to demonstrate that better outcomes equal cost savings and improved consumer experience. This improvement includes determining the most successful way to merge information from different health records, allowing for a single care plan. Additionally, the CRC aims to determine its optimal approach towards population health and payment reform. The program will receive support and technical assistance from Colorado Health Information Organization (CORHIO) and HealthTeamWorks, the two SIM Practice Transformation Organizations (PTOs) working with the Integrated Health Home.

Instead of working from unified electronic health records, this project will identify ways to share data across systems and electronic records to remove the barrier of having one electronic record that meets all of the requirements and regulations for physical and behavioral health care. This adjustment will give the CRC team a greater understanding of its population via population health data mining.

Participation in this project will aid CRC and Salud Family Health's Integrated Health Home in understanding the true cost of integrated care and alternative payment methods with the goal of delivering effective and affordable care. This project will allow for understanding the cost of care and participating in conversations regarding alternative payment methods.

Program successes include learning how to do small but effective continuous quality improvement (CQI) projects that engage the team and help it move towards more integration. Identifying small data points that give the staff quick feedback about the results of their efforts has been very successful. One recent example is the accurate capturing in the medical record of the consumer's preferred language. At the beginning of the project, 48% of consumers had an "unknown" language; after two months of the project, this response had reduced to 19% of consumers having an "unknown" language. The program also successfully started two Consumer Advisory Panels: one

in English and one in Spanish. These groups provide consumer voice and feedback about the services offered.

A major challenge has been working with another organization that provides the medical services. It took a considerable amount of time to facilitate the staff working well together, after which the medical provider gave notice that he would retire. Since his retirement in December 2017, the CRC has not had a consistent provider in place. Rather, there have been several different providers that cover the hours but were not integrated as part of the team, resulting in consumers not being able to develop a stable provider relationship.

Another challenge has been dental care. The program started the project with a company that provided dental care two days per month. In July, the company experienced some financial difficulty and had to withdraw its services. CRC has subsequently found a prospective company and is working to secure the necessary agreements.

Jefferson Center for Mental Health

Jefferson Center for Mental Health (Jefferson Center) is the private, nonprofit community mental health center serving Jefferson, Gilpin, and Clear Creek counties. Jefferson Center is partnering with the Metro Community Provider Network (MCPN), the local Federally Qualified Health Center, to create the Jefferson Plaza Family Health Home (JPFHH) in Lakewood, Colorado. The two partner agencies have a strong history of collaboration on other integration projects, some spanning over two decades. This project is helping to extend the current integration efforts to all children and families seen by MCPN through the JPFHH.

JPFHH primarily serves those most in need: 73% of enrolled patients had serious mental illness (SMI); 84% had incomes below the poverty level. Patients with Medicaid comprise the largest payer source, but patients with private insurance are also served.

JPFHH mainly serves children and families who lack a primary care provider and would benefit from integrated care. This population includes individuals with SMI, serious

emotional disorders (SED), substance use disorders (SUD), and those with less severe behavioral health needs. All patients have access to a range of services from health coaching and care coordination to intensive in-home services for families of children with severe behavioral challenges.

JPFHH members will receive the appropriate level of care, ranging from intensive mental health treatment to prevention and wellness services. In addition, children and families seeking behavioral health services from Jefferson Center who already have a non-MCPN PCP will receive care coordination between their community PCP and Jefferson Center, although these patients are not considered part of the SIM cohort. Members will remain enrolled regardless of their diagnoses or participation level. All patients of the health home will, at a minimum, receive behavioral health screening to identify risk, prevention, and early intervention of behavioral health concerns. These services may include brief intervention, mental health and/or SUD treatment, basic education, wellness services, navigation support, resource information, and more intensive behavioral health services, as needed.

Jefferson Center and MCPN meet weekly as a multi-disciplinary team to review and staff at-risk patient and family and to develop a coordinated plan of care. Jefferson Center and MCPN have a CQI team that reviews data on program effectiveness throughout the course of the initiative period and beyond. This team comprises staff from both partner agencies with support and technical assistance from HealthTeamWorks. JPFHH staff also meet with the technical advisor from Colorado Regional Health Information Organization (CORHIO) every three to six months to address issues of health information exchange. JPFHH will build towards the capacity to analyze the effectiveness of treatment for patients and to use these data to drive best practices.

As part of this project, Jefferson Center has contracted with a team from the Colorado School of Public health, led by a health economist, to develop a possible pilot payment model based on the data gathered at JPFHH. This work includes analysis of encounter, claims, and utilization data as well as startup costs and non-reimbursable clinical services. This focus on payment reform is a new and critical component of Jefferson Center’s integration efforts, as existing integrated services are not sustainable. The current payment methodologies (e.g., fee-for- service in primary care, carved-out capitation in behavioral health) are not conducive to team- based, whole-person healthcare. Jefferson Center is confident in the project’s ability to both develop and implement SIM sustainability activities through this effort.

The program's ongoing challenges have included Arapahoe House closing and thus having to withdraw from the clinic, turnover in the MCPN upper administration, and provider turnover. Losing Arapahoe House lead the program to incorporate substance use treatment into the duties of the Behavioral Health Provider (BHP). Difficulty finding a qualified BHP who was both a Certified Addiction Counselor (CAC) and had child and adolescent experience created a delay in hiring. When MCPN upper management turned over, the new administration had a learning curve about SIM and the role and ambition of the JPFHH. Lastly, there was significant turnover in primary care providers. This turnover has led to difficulty building the empanelment and offering consistency in the program.

However, the challenges have also lead to successes. Jefferson Center hired a BHP who was willing to obtain her CAC and will have a unique set of skills to treat children and families in primary care. The turnover in MCPN management staff led to fresh ideas and a renewed commitment to integration. They now have a cohesive team between MCPN and Jefferson Center as well as a fully staffed team—though they are still struggling to find a family practice primary care provider. The BHP has been instrumental in transforming the culture between the two organizations and bringing cohesion and strong clinical value to the work at JPFHH.

With the new successes, the Jefferson Center will able to build and grow JPFHH and has seen recent increases in the numbers of patients being served. They project that by July 2019, they will reach their target goal of 3,000 patients served.

The team is committed to prevention and early intervention of behavioral health issues. Because of this, they have been able to consider new ways to assess risk in children who show potential risks for childhood trauma, bonding issues, and social determinants of health.

Another success resulting from having a full staff is the ability to innovate and create workflows to address additional care gaps and other clinical interventions that present in the clinic and with support providers.

The ongoing challenges continue to be Health Information Exchange (HIE) as well as sustainability; these challenges are continuously being addressed.

Mental Health Partners

Mental Health Partners (MHP) is a private, nonprofit CMHC that has provided mental healthcare to the Boulder and Broomfield communities for over 55 years. MHP remains the only organization providing comprehensive behavioral health services to

residents of Boulder and Broomfield counties regardless of ability to pay. MHP has expanded its long and successful partnership with Clinica Family Health, the local Federally Qualified Health Center, and its newer partnership with Dental Aid, a comprehensive dental care provider, to create a multi-agency collaborative effort with the goal of providing whole-health care for adults with serious mental illness (SMI) or substance use disorders (SUD).

According to MHP and Clinica data, 92% of MHP's clients with SMI and 70% of Clinica's adult clients are very low income, with only a fraction of each agency's total population living on a moderate income. Patients with a variety of payment sources are served including those with Medicaid, Medicare, commercial insurance, and private pay.

The Boulder Integrated Health Home (BIHH) is leveraging funding from SIM and other sources to create a sustainable, integrated health home for adults with SMI and/or co-occurring SUDs in the City of Boulder and Boulder County at MHP's Ryan Wellness Center. Through this collaborative partnership, MHP, Clinica, and Dental Aid share a vision of creating a healthcare experience that is simple and seamless, inspires self-confidence, and results in superior health and life outcomes for adults with serious behavioral health concerns. The partner agencies share a devotion to client-focused practices and quality improvement efforts to ensure high- quality whole health care for the most vulnerable in the served communities. The Boulder Integrated Health Home

also seeks to improve access to care for traditionally underserved subpopulations, such as Hispanic/Latino individuals, individuals who are homeless, and those with cognitive impairments related to their mental health conditions.

Current or incoming MHP clients who have a primary care need are identified by a behavioral health assessment specialist or their current treatment team through a detailed evaluation of health concerns. The provider discusses with clients whether they already have a PCP and if they routinely access that provider for their physical healthcare. Clients who either do not have a PCP or who are not accessing their provider and could benefit from the integrated services are referred to the Boulder Integrated Health Home.

The Boulder Integrated Health Home has a multidisciplinary team of providers who can work with the client based on an individualized whole-health treatment plan, including a psychiatrist, health coach, behavioral health professional, nutritionist, dental hygienist, and more. Each client is also introduced to the team's Peer Support Specialist, who can meet together and prepare for the client's medical visits, accompany the client to the first appointment, introduce the care team, facilitate health and wellness groups, and provide a unique and valuable form of overall support for health behavior change. For any individuals joining the Boulder Integrated Health Home who are new to Clinica, an initial financial screening appointment is set to eliminate any financial barriers to care. Upon arrival at the appointment, Clinica staff check in the patient and review any needed paperwork or outcome assessments, and a medical

assistant and primary care provider conduct a comprehensive physical evaluation and order any needed labs or follow-up care. The team's Behavioral Health Professional (BHP) is available to join visits with the medical provider as needed; the BHP can also work directly with the client to identify health goals and monitor progress in achieving those goals. Reception staff assist clients in scheduling any required follow-up visits with their primary care team, specialists, Health Coach, and/or other team members.

The BIHH provides integrated primary care, behavioral health, and dental services to clients with centralized coordination by a multidisciplinary care team. The services are delivered as a cohesive team in one location, with providers situated in close proximity to one another for daily planning and real-time, face-to-face consultation. The ultimate goal is to move toward a fully-integrated and sustainable service design by informing a

new bundled payment model that covers traditionally non-covered services necessary to ensure good access to care, coordination of care, outreach and engagement, and family/community support and education. SIM provides the Boulder Integrated Health Home with the startup capacity to build a full panel of clients and work toward full integration of behavioral and physical health in community behavioral healthcare. This startup period also allows the partnership to stratify risk to manage utilization and maximize payment by level of need. The program receives support and technical assistance from Colorado Health Information Organization (CORHIO) and HealthTeamWorks, the two SIM PTOs.

Another key aim is to create shared access to the health-risk data that are vital for taking action and improving whole-health outcomes for some of the most vulnerable members of the community. Each partner organization shares key data elements so that the full treatment team can access and take action on health information; some data sharing occurs via automated mechanisms, while some occurs via manual processes during daily huddles. Client registries track chronic health conditions, behavioral health information (e.g., diagnosis, prescriptions, treatment objectives), complex care needs, and both physical and behavioral health outcomes. The client registries also inform continuous quality improvement efforts, with a focus on reducing disparities among subpopulations. In addition, MHP and Clinica are highly motivated to partner together to build advanced business intelligence and data systems.

The Boulder Integrated Health Home has experienced many successes and challenges in its first two years. Enrollment has occurred at a far faster pace than expected, indicating that the pent- up need in the community was significant. Another key success has been the strong teamwork mentality that staff have built together. The team has made considerable effort to learn the vastly different cultures in behavioral health and primary care organizations and to build a unique environment that holds client-centered care at its core.

A key challenge for the team is the lack of a shared electronic health record. Business intelligence staff at MHP and Clinica have worked to create a protocol of data sharing that includes exchanges of aggregate primary care utilization data (e.g., PCP no-show rates, PCP appointments filled, etc.) and automated exchanges of individual

patient-level data including psychiatric medications prescribed at MHP, vital signs, and other physical health data (e.g., blood pressure, BMI, lipid panel, HgbA1c). While these solutions do enhance whole-health care for patients across behavioral and physical health, the lack of a truly integrated electronic health record is still a challenge. These data exchange processes, both manual and automated, still serve as a workaround to a truly integrated record.

Another key challenge is the difference in the payment structures across behavioral health and primary care. Developing an integrated, value-based payment model that covers the type of care needed to improve the health of this complex population requires significant adjustments across systems. The BIHH serves a population with SMI and highly complex needs related both to health conditions and social determinants (e.g., half of all BIHH clients are homeless, the vast majority live under the federal poverty level, and many have significant transportation challenges). The complexity of co-occurring health conditions—including diabetes, high cholesterol, obesity, metabolic syndrome, SMI and cognitive challenges, and addictions— is very high.

Southeast Health Group

Southeast Health Group (SHG) is the private, nonprofit CMHC providing mental health, substance use, primary care, and wellness services to the six-county, rural and frontier region in the southeastern corner of Colorado that includes Baca, Bent, Crowley, Kiowa, Otero, and Prowers counties. Since 2013, SHG has sustained a successful primary care program within its La Junta behavioral health home. The SIM initiative provides an opportunity for SHG to expand this integrated health home model across all six counties with access to bi-directional services in the La Junta, Rocky Ford, Lamar, and Las Animas offices. With the addition of another in-house primary care team, SHG will reduce the wait list for primary care services from three weeks to two weeks.

Twice as many residents of southeast Colorado live in poverty (23.5%) as compared to the statewide average (12.9%). Likewise, prevalence in four of five indicators of poor health (obesity, tobacco use, diabetes, heart disease, and cancer) is significantly higher in southeast Colorado.

The SHG Integrated Health Home targets individuals living with one or more chronic health conditions, including a behavioral health disorder, and provides a full continuum of comprehensive physical health, behavioral health, and wellness services to children, adolescents, and adults with co-occurring behavioral and physical health conditions

SHG completed renovations to outfit two exam rooms and a lab in its Lamar office to accommodate the team one day per week. Because of their ability to add a second provider through SIM, SHG was also able to open a fully-integrated clinic in Las Animas, serving Bent County. A family nurse practitioner (FNP) in that office provides services one day per week but aims to increase case load, serving many clients from Fort Lyon.

The integrated health home provides six comprehensive services, including care management, care coordination, transitional care, health promotion, individual/family supports, community referrals, plus use of a fully-integrated electronic health record. It is population-focused for high utilizers with one or more chronic health conditions. The model uses team-based care, including medical prescribers, MH clinicians, SUD counselors, a nurse, a health coach, physical trainers, health navigators, a physician assistant, a family nurse practitioner, and a medical assistant. Following health screening assessment, patients are assigned to risk levels and provided with appropriate care coordination based on need. A coordinated plan of care is based on a complete and comprehensive health assessment collected in a single EHR. Periodic reviews based on new assessments may result in adjustments in the assigned risk level. Typically, a patient does not leave the system unless he or she dies, moves out of the area, or chooses a different provider. However, should patients meet their health goals and fall into a category of “healthy,” they do step down through an annual wellness visit for prevention, well care, and minor acute services.

Since no data sharing with an external partner will be necessary, SIM funding will support implementation of a single electronic health record with the capacity to hold integrated health data. The center, in its move toward sustainability, continues to

evaluate appropriate payer sources; these aim to include third-party payers on an annual basis, ensuring that providers are contracted and credentialed in order to achieve the highest reimbursement possible. The center will receive support and technical assistance from CORHIO and High Plains Research Network, the two SIM PTOs working with SHG.

SHG is the only recipient of Bi-Directional Integration Health Homes dollars that hires in-house primary care providers. Therefore, SHG experiences a unique set of challenges. When primary care started at SHG, it was always understood that the pace could be slower for more complex patients, and time was built into the provider's schedule to accommodate more time with patients who have higher needs. Because of that understanding, providers began to schedule longer time slots for all patients, giving way to higher complexity as patients were able to share

long medical histories. The pattern became more evident when the primary care providers were asked to assign risk levels to their patients. Most patients scored 5 or 6, which would indicate a patient is near death. This relates to the conclusion that patients are able to increase complexity simply by spending more time with the Provider. SHG is working with its Practice Facilitator to increase productivity by better understanding cycle times and provider and patient patterns.

SHG has identified challenges with contracting with third party payers, noticing that the reimbursement rate from those payers is an average of 75% of the Medicare rates. As SHG works through renegotiating those contracts, it is having little success changing any contracts to insure an agreeable rate of reimbursement. Likewise, credentialing providers, whether behavioral health or primary care, remains a large burden for the agency, necessitating the addition of a credentialing specialist. As such, additional analysis must be conducted to determine which payers have enough utilization for the program to continue to contract and credential with.

Despite challenges, SHG has experienced some success with strategies to improve productivity as one provider's caseload has continued to increase. That provider has become a significant provider for Ft. Lyon clients needing primary care. SHG is also a specialty care provider for MAT in Lamar, continuing to see MAT patients once every other week in that clinic. SHG was able to secure funding for alternative pain management because of its Suboxone program, which has been very successful. Two

pregnant women were assisted through pregnancy on Suboxone and delivered successfully.

Using the technical assistance available through its SIM Practice Facilitator, SHG was able to implement a risk stratification model, and providers are working to attribute baseline risk levels to all patients prior to July 1, when the new Regional Accountable Entity (RAE) contract begins. Also, SHG identified areas of need and is working with a certified coder, a financial counselor, and a credentialing specialist to fill in those areas. Finally, the EHR will be fully integrated when SHG's last primary care provider goes live on April 1, 2018.

Patient Attribution

Attributing patients to each of the four CMHCs is a complex task and differs considerably from the claims-based methodology used to attribute patients to the SIM primary care practice sites. After considerable discussion and contemplation, the CMHCs decided to use their internal data files to construct their own patient panels to submit to CIVHC for attribution in the All Payer Claims Database. Attributions do not reflect a total count of all patients being seen by CMHCs; rather, they represent the specific populations targeted most intensively for SIM-funded

interventions. The table below outline's the specific methodology used for attribution by each CMHC.

Table 1: CMHC Attribution Methodologies

Community Reach	All patients with a diagnosis of SMI who receive primary care services at the Commerce City Clinic location.	Jan–July 2017 1,675
Jefferson Center for Mental Health	All patients who received primary care services at the Jefferson Plaza Health Home.	Jan–July 2017 614
Mental Health Partners	All patients with a diagnosis of serious mental illness (SMI) who receive primary care services at the Ryan Wellness Center location.	Jan–July 2017 400

Southeast Health Group All patients who received primary care services at any of the four clinic sites (La Junta, Rocky Ford, Lamar and Las Animas) that provide primary care.
Jan–July 2017 1,852

Total CMHC Attribution Jan–July 2017 4,541

Figure 1: Number of Patients Attributed to the CMHCs[7]

Practice Transformation

The data summarized in this section are from the Integrated Practice Assessment Tool (IPAT),[8] the Comprehensive Primary Care Practice Monitor – Mental Health Center Version (Monitor), the Milestone Activity Inventory (the "MAI," which was later modified and became the

[7] 90% of patient lists matched records in the APCD. [8] Waxmonsky, J., Auxier, A., Wise-Romero, P., & Heath, B. Integrated Practice Assessment Tool (IPAT). Available at https://www.integration.samhsa.gov/operations-administration/IPAT_v_2.0_FINAL.pdf. Additional information is available at the SIM resource hub: http://resourcehub.practiceinnovationco.org/2017/02/03/ipat/

Milestone Attestation Checklist "MAC"), the Practice Improvement Plan (PIP), and the Clinician and Staff Experience Survey (CSES).

This section summarizes these practice transformation data for the four CMHC Bi-Directional SIM efforts. To offer a comprehensive view of all four CMHCs, we selected April 2017 as a baseline. We chose this date because (1) data are available for all assessments at that point and (2) CMHCs did not officially begin until late in 2016 (though CMHC IPAT data are also available from August 2016 and will be included in the summary).

In addition to this baseline CMHC data, SIM cohort 1 baseline practice site data are presented, providing a contrast to the April 2017 CMHC data. These practice site data are included for all 92 cohort 1 sites that completed the two-year cohort 1 timeframe. Those 92 sites completed follow-up assessments and will provide ongoing perspective on CMHC SIM initiative change. Cohort 1 baseline data were collected in April 2016.

Although these comparisons may be helpful, some caution is appropriate: both the approaches of the CMHCs and the populations they target differ significantly from most of the primary care practice sites. However, understanding both the similarities and differences in the approaches may be helpful in identifying best practices useful to all of

the centers.

Integrated Practice Assessment Tool (IPAT)

Figure 2 (next page) shows IPAT levels of integration in August 2016 and April 2017 for the four CMHCs. The IPAT is a tool that uses a decision-tree model to place practice sites into discrete collaboration/integration categories. While it is a useful tool for sites to understand where they are on the integration continuum, SIM does not expect all practice sites (including the CMHCs) to necessarily reach the highest levels of integration during their participation in SIM.

At both points in time, half (two of the four) of the CMHCs were assessed at level 4 (co-located), and the remaining half were at level 5 (integrated). Two of the four stayed at the same level from August 2016 to April 2017 (one level 4 and one level 5). The other two experienced changes as one shifted from co-located (level 4) to integrated (level 5), and one changed from integrated (level 5) to co-located (level 4). The shifting down one level of a CMHC is not surprising. Sometimes, organizations completing the IPAT have lower levels on second assessment because they better understand those things they are and are not doing well. In addition, the start date for CMHC funding was delayed until later in 2016. The CMHCs were unable to use SIM dollars to fund clinical positions that were originally planned. These positions ultimately had to be paid by other means or eliminated 6–9 months into the project. By eliminating these key non-reimbursable clinical positions, some of the CMHCs may have dropped to a lower level of integration during this time.

Figure 2: IPAT Level of Integration for CMHC Programs

Figure 3 and Table 2 (on the following page) show IPAT levels at baseline for the CMHCs and the cohort 1 SIM practice sites. All four CMHCs were included, and the 92 practice sites that remained in SIM over the cohort 1 two-year period were included. As noted, two of the CMHCs were at the co-located level (50%), and two were at the integrated level (50%). In comparison, 27.2% of the practices sites were at the co-located level of integration and 30.4% were integrated. As mentioned earlier, the CMHCs all had experience with integrated care prior to SIM and would be expected to be at relatively higher levels of integration. In addition, there are only 4 CMHCs compared with 92 primary care practice sites in cohort 1. Primary care practice site data provided in earlier quarterly evaluation reports clarify that practice sites (n=92) varied more in the level of integration than did the CMHCs.

Level 4 criteria requires “closer collaboration (than level 3) among primary care and behavioral health providers due to co-location in the same practice space” and evidence of the “beginning of integration in care through some shared systems.” In other words, these criteria require that provider relationships go beyond referrals, with an intent to achieve shared patient care. Level 5 is “integrated” (by definition in the IPAT), and CMHCs at this level show increasingly desired aspects of integrated care such as being “on the same team” with an “in-depth understanding of each other’s roles and areas of expertise.”

Figure 3: IPAT Levels of Integration (Baseline)

The table below shows the number of CMHCs and cohort 1 practice sites with percentages for each of the levels of integration.

Table 2: IPAT Levels of Integration (Baseline)

Integration Level	Practice Sites	CMHCs
Level 0 Pre-Coordinated	5	5.4%
Level 1 Coordinated Minimal Collaboration	4	4.3%
Level 2 Coordinated Basic Collaboration	11	12.0%
Level 3 Co-Located Basic Collaboration	6	6.5%

- Level 4 Co-Located Close Collaboration 25 27.2% 2 50.0%
- Level 5 Integrated Close Collaboration 28 30.4% 2 50.0%
- Level 6 Integrated Full Collaboration 13 14.1%

Total / Percent 92 100% 4 100%

As part of our evaluation, we will follow CMHC levels of integration over time to determine whether these levels change. At the 12-month follow-up assessment point, cohort 1 practice sites demonstrated change in the number and percentage of sites moving into levels 4 or higher. However, much of that change involved sites at levels 3 or lower moving to levels 4 or higher. Since all CMHCs are already at the higher levels 4 or 5, shifts toward higher integration levels by the 12-month assessment will likely be less dramatic than the shifts for practice sites.

Comprehensive Primary Care Practice Monitor: Mental Health Center Version

The Comprehensive Primary Care Practice Monitor Mental Health Center Version (Monitor)[9] will be completed annually by CMHCs to provide progress ratings on the implementation completeness of the building blocks of practice transformation, based on Dr. Thomas Bodenheimer's conceptual framework, “Building Blocks of High-Performing Care.”[10] Items within each of the 11 building blocks[11] are rated on a 5-point scale from 0 (“not at all”) to 4 (“completely” or “is now routine across the entire practice”). The charts in this section present Monitor data as the percentage of the maximum possible score across the 59 distinct items comprised within the 11 Monitor building blocks. The 11th building block specifically addresses integration of primary (physical) and behavioral healthcare. The Monitor was revised by UCDFM to be more relevant to the unique work of the CMHCs.

Since the rating on any given item can range from 0 to 4, the maximum possible score for the 59 item ratings is 236 (59 items multiplied by a maximum score of 4 on any item). The total ratings for each of the four CMHC practice monitors is divided by 236 to obtain the percentage of the maximum possible score. Since each individual site has

selected which activities and which building blocks to focus on in its integration efforts, no site is expected to achieve a 100% of the total score. Rather, increases in scores indicate progress in completing the building blocks for a site's integration goals.

Data presented in this section show clear improvement, on the whole, in the degree to which practice transformation is occurring in the CMHCs, as indicated by progress in implementing the building blocks. More specifically, the CMHCs are showing progress in their integration of primary (physical) care into their existing behavioral health care models.

[9] For more information, see the SIM resource hub: http://resourcehub.practiceinnovationco.org/2017/02/03/medical-home-practice-monitor/ [10] Bodenheimer, T., & Willard, R. (2012, April). The building-blocks of high-performing primary care: Lessons from the field. California HealthCare Foundation. Retrieved from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20B/PDF%20BuildingBlocksPrimaryCare.pdf [11] There are 10 primary building blocks, plus an additional block particularly related to "Behavioral Health Integration."

Figure 4 shows overall average scores for the CMHCs and the cohort 1 practices at baseline. The average percent of maximum possible score for the four CMHCs is 65.4% (represented by the green bar), indicating that, on average, the CMHCs have fully implemented two thirds of the overall building block components. This figure is similar to the 66.1% average score for the 92 cohort 1 practice sites that completed the two-year SIM cohort period (represented by the blue bar). The average 65.4% of maximum possible score for the CMHCs translated to an average rating score of 2.61 (65.4% of a possible 4 on the 0-to-4 rating scale).

The specific Practice Monitor building block (#11), which focuses on Behavioral Health Integration (BHI),[12] contains 14 items for the cohort 1 sites and 13 items for Primary

Care and Behavioral Health Integration (PCBHI) for the CMHCs. The average PCBHI percent of maximum possible score for the CMHCs in August 2016 and in April 2017 are shown in Figure 5.

The change in average CMHC BHI shows that efforts have resulted in definite improvement in the degree to which primary care and behavioral health are being integrated in the CMHCs.

[12] Practice sites use "BHI" whereas CMHCs use the "PCBHI" terminology. In this report, "BHI" is used for clarity, though the Monitor for the CMHCs addresses Primary Cary Behavioral Health Integration (PCBHI).

Figure 4: Average Percent of Overall Maximum Score

Figure 5: Physical-Behavioral Health Integration Average

The average BHI percent of maximum possible score for the CMHCs and for cohort 1 practice sites are shown in Figure 6, below. The CMHCs average 71.2% of the maximum possible score for the BHI items at baseline, while the cohort 1 sites average 61% of the maximum possible score. The gap between CMHC average and cohort 1 average likely reflects that all CMHCs were at a level of integration of 4 or higher on the IPAT whereas the cohort 1 sites' levels were more variable. Overall, CMHCs started in very different places in their journeys towards greater integration than most of the primary care practice sites.

The percentage of maximum possible score on the BHI items equates to an average rating score of about 2.85 out of 4 for the CMHCs and an average item rating score of about 2.44 for the cohort 1 practice sites.

SIM Milestone Activity Inventory (MAI)

SIM CMHCs also initially assessed their success in completing detailed activities aligned with 10 primary building blocks using the Milestone Activity Inventory (MAI).[13] All four CMHCs completed a MAI in April 2017. The building blocks and the number of milestones (activities and steps) are shown in Figure 7 (Page 31). For continuing assessments, the SIM initiative changed this to be a Milestone Attestation Checklist (MAC), a revised MAI that was developed for cohorts 2 and 3 practice sites. Those data are presented later in this section.

Each of the primary building blocks has one or more related activities; each activity has one or more steps. As these steps are completed to **establish** that activity, a practice site moves closer to implementation of the building block.

[13] The CMHCs have switched over to the Milestone Attestation Checklist. This tool was used for their second milestone assessment and will also be used in future assessments. For more information, see the SIM resource hub: http://resourcehub.practiceinnovationco.org/2017/02/03/milestone-inventory/

Figure 6: Physical-Behavioral Health Integration Average Percent

Each CMHC rates its status on each of these activities/steps by choosing one of the following ratings:

- Not addressing at this time
- Some work on this has been done but could be improved
- Well-**established** workflow already in place

TriWest calculated completion scores for each building block to describe where CMHCs fell along a continuum ranging from 0% (completed none of the milestones for the specific integration building block) to 100% (completed all milestones associated with the building block). An overall completion index was also calculated to show average completion across the 11 building blocks for integration. For example, there were four milestones (activities/steps) for "Engaged Leadership." The maximum possible score on those is 12 (four milestones multiplied by a score of 3). For each CMHC, the percent of milestones established in the table was calculated as the site's total score divided by the maximum score possible. The overall completion index averaged the scores of the 10 building block scores.

Figure 7 (next page) shows each building block and the percentage of milestones completed or established for that building block. For example, at 93.8% Engaged Leadership averaged the highest percentage of milestones established for the four CMHCs. Continuity of Care and Care Coordination were the areas in which the achievement of milestones was least developed, on average, across the four CMHCs. The relatively high average scores on the first four building blocks is understandable as these are foundational for integrated care. The six more advanced building blocks (numbers 5 through 10) show lower scores, indicating lower initial progress in those areas. The overall average building block score shows that an average of 69.5% of milestone activities/steps were well-established in the daily work of the practice site.

Scores for four individual centers varied widely. The site with the fewest number of "**established"** (i.e., well-established workflow is in place) milestones reported 53.3% of the milestones achieved, while the highest reported 83.3% "established."

Figure 7: Percent of Building Block Milestones Established

Success Story: Team-Based Care CRC has focused on crafting an efficient, team-based system of care for their patients, who often face multiple, co-occurring health conditions. The Quality Improvement team at CRC has been refining a new intake process for Medicaid clients, with the goal of increasing enrollment and engagement in the health home. The revised intake includes an appointment with the bilingual Care Coordinator. This appointment allows her to complete initial baseline assessments and provide the patient with information on the health home model. She also supports prompt scheduling with both physical and behavioral health supports for ongoing care. CRC saw a 7% increase in enrollment and engagement in the health home within the

first month.

Table 3, below, compares the average baseline CMHC scores with cohort 1 baseline scores. The most striking differences are in the first two building blocks in which the CMHCs' averages are higher, showing more Leadership Engagement and Data-Driven Improvement. However, cohort 1 practice sites were notably higher in Continuity of Care and Care Coordination. The differences seen in this table reflect the significant differences in both the structure of the CMHCs as compared to primary care practice sites and in how each group approaches integration.

Table 3: Percent of Building Block Milestones Completed/Established

CMHC Cohort 1 1. Engaged

Leadership 93.8% 71.2% **2.** Data-Driven Improvement 83.3% 76.4% **3**. Empanelment 74.4% 71.1% **4.** Team-Based Care 73.6% 79.0% **5.** Patient-Team Partnership 61.7% 63.5% **6.** Population Management 59.8% 64.3% **7.** Continuity of Care 58.3% 67.0% **8.** Prompt Access to Care 66.7% 66.8% **9.** Care Coordination 57.8% 64.4% **10.** Integration & Payment Reform 65.2% 67.4% **Average of Building Blocks 69.5% 69.1%**

Again, each site—whether a CMHC or a primary care practice site—chooses to move through these building blocks in different ways, focusing more on some than others. As such, any individual percentage may be misleading as a complete measure of success. Rather, the overall increase in the number of milestones completed is the best measure of practice transformation.

Success Story: Patient-Team Partnerships The health home team with their Practice Facilitator identified a major challenge in coordinating psychiatric appointments to coincide with their primary care providers' appointments. These joint scheduling conflicts led them to create an in-house psychiatric consultation model to give medical staff an expedited opportunity to begin addressing mental health needs, even before an actual appointment with a psychiatrist can be arranged. This leverages the primary care provider's willingness and interest in prescribing psychiatric medications and allows the team's psychiatrist to provide education and support. This has prompted the QI team to focus on clarifying the role of each team member and producing a brochure for patient navigation that will allow both the clients and the staff to fully understand the flow of care in the health home. This directly supports Building Block 5: Patient-Team Partnership.

Since milestone activity progress is assessed bi-annually, CMHCs completed another Milestone Activity Inventory in November 2017. However, the CMHCs have shifted to the Milestone Attestation Checklist (MAC) developed for cohort 2. The MAC is meant to respond to two main concerns.

The first concern was that cohort 1 practice sites and CMHCs were free to choose which building blocks and milestones to focus on for their activities. This approach was meant to allow sites and CMHCs to meet their own priorities. However, the unintended consequence was a perception of too little structure and guidance about how to progress through the building blocks.

The second concern was that cohort 1 practice sites and CMHCs needed a way to demonstrate progress to payers, in a consistent manner, in moving forward to integrated care. Payers provided input into the process of identifying priority milestones and a "good standing" process for primary care practice sites; it is important to note that this process does not apply to the CMHCs as they are not participating in alternative payment models. The development of the good standing process, however, led to the creation of the MAC so that PTOs could help guide practice sites through the required

milestones in an appropriate time frame. The revision resulted in an initial focus on foundational building blocks that was followed by a focus on more advanced building blocks.

Changes to the milestones are reflected in the MAC. In addition, the completion scale was changed from the 3-point scale to a 4-point scale: (1) “Not Started,” (2) “Just Beginning,” (3) “Actively Addressing,” and (4) “Completed.” The Practice Facilitators providing technical support attest to the completion of the MAC for each CMHC.

Because of the variability caused by changes to building blocks, respective item content, and rating scale, a side-by side comparison of the April 2017 and the November 2017 building block ratings is not presented here. However, as the intent of the two instruments is the same, an assessment of the overall degree to which CMHCs are implementing milestones through completion of activities does seem warranted. Although this comparison should be considered with caution, the November 2017 MAC assessment average score of 78.2% suggests improvement in percentage of milestones already “established” that are necessary for integrated care as compared to the April 2017 baseline average of 68.5%.

Practice Improvement Plan

Once CMHCs completed initial assessment tools, results were used to develop a Practice Improvement Plan (PIP). The PIP tool requires CMHCs to select at least one (and no more than two) milestone activities in each of three focus areas from the framework of 10 possible building blocks. The selected milestone serves as a goal in

each of the following three SIM initiative focus areas:

- Practice Transformation
- Physical Health
- Health Information Technology (HIT)

All four CMHCs initially selected one goal and had the option to add a second goal in any, or all, of the three initiative areas. Table 4 (next page) shows the building block targeted by each center, the specific goals that will help to address that building block, and a description of each goal.

Fifty percent (6 of 12) of the goals were from the Population Management building block. Considering the milestone summary above, this was one of the areas with relatively lower completion and, thus, was an area in need of focus, averaging 59.8% completion across the four sites. Five of the other six goals are from separate building blocks (2, 3, 5, and 9). Goal 4 was the exception, with two goals chosen from that building block.

Success Story : Population Management Southeast Health Group (SHG) has made significant progress toward Building Block 6, developing a comprehensive risk stratification model and actively managing its patient population leveraging related data. The stratification model has been applied to all patients enrolled in behavioral health, primary care, and physical therapy services available at the integrated health home. SHG is currently refining its treatment strategy by stratifying patients in order to identify care gaps and appropriately prioritize high-risk patients and families.

Cohort 1 practice sites differed somewhat in the building blocks chosen for goal areas. Building block 6, Population Management, was the second-most-chosen goal area with 28% of the practice site goals selected from this block. Building block 2, Data-Driven Improvement, was the most frequently chosen by practice sites, with 34% of site goals from that building block compared with only 1 of the 12 (8%) chosen from that building block by a CMHC. This variance in selection once again reflects the differences in starting points, implementation strategies, and populations targeted for integration between CMHCs and the primary care practice sties.

Table 4: PIP Goals at Baseline

Building Block Number (SIM Focus Area)	Goal
Practice Transformation BB-3. Empanelment Identify workflow and processes needing further integration in order to deliver seamless care to patients BB-4. Team-Based Care Develop roles and tasks of the care team for clarity and also to assist clients/patients with understanding the Health Home BB-5. Patient-Team Partnership Create an Integrated Patient Advisory Council BB-6. Population Management Develop an algorithm to risk-stratify SIM patients. Complete this goal and begin documenting in the next six months **Physical Health** BB-4. Team-Based Care Improve coordination of care across primary care, behavioral health, and dental care, including improving daily huddles and information sharing BB-6. Population Management Risk-stratify patients, referring high-risk patients to direct to care management and other services. Complete risk stratification within next six months BB-6. Population Management Develop Evidence-Based Guidelines for treatment for maternal depression BB-6. Population Management Improve the health and wellness of adult clients/patients who have a BMI >30 **Health Information Technology** BB-2. Data-Driven Improvement Work with CHITA and local IT team to establish spreadsheet for SIM to meet CQM reporting requirements within next three months BB-6. Population Management Develop initial registry of patients BB-6. Population Management Develop capability to share information seamlessly across organizations BB-9. Care Coordination Participate in a Health Information Exchange to enhance coordination of care	

Success Story: Team-Based Care and Data-Driven Improvement

Jefferson Center screens mothers with the Edinburgh Postnatal Depression Scale and has now expanded depression screening to include other caregivers associated with

the new baby. These caregivers are screened using the PHQ9 and then successfully connected to a continuum of services when appropriate. New fathers have been a key target audience and have been receptive, though in some cases surprised, to see their own mental health as a consideration after the baby is born.

CMHC and Cohort 1 Satisfaction Survey

Clinician and Staff Experience Survey

The goal of health care reform in the United States is often referred to as the Triple Aim: better health of populations, improved patient experience of care, and reduced per capita costs. More recently, a fourth goal has been adopted by many organizations, including Colorado SIM, advancing the Triple Aim to the Quadruple Aim. The fourth aim is to preserve, or even enhance, the satisfaction of the workforce. To assess this aim, the University of Colorado conducted a Clinician and Staff Experience Survey. The survey contains an item on overall satisfaction, another 14 items on aspects of satisfaction, and a question asking respondents to describe their situation at work in terms of burnout. Responses to the overall satisfaction and the staff/clinician burnout item are reported below. Surveys were distributed to CMHC staff and their participating integration partners and completed in Spring 2017.

Figure 8, below, shows CMHC and cohort 1 practice site baseline responses to the first survey item: “Overall, I am satisfied with my work in our practice.” The distribution of ratings in the following figure shows about 81% of CMHC respondents either agreed or strongly agreed that, overall, they were satisfied with their work in their practice (4.0 average score on the 5-point scale). The CMHC response is comparable to the cohort practice sites, about 83% of whose respondents indicated either agreement or strong agreement with being satisfied with their work in their practice site (4.1 average score on the 5-point scale).

Figure 8: Satisfaction Survey: Overall Satisfaction with Work

In addition, the composite percent of maximum possible satisfaction score was calculated as the average percent of possible satisfaction scores across the 15 satisfaction items. The

composite satisfaction score averaged 60.5% at baseline for CMHCs, meaning that 60.5% of CMHC staff and clinicians responded they either agreed or strongly agreed that they are satisfied with their work. Primary care practice sites (which had a much higher number of respondents) had a similar response, with 65% either agreeing or strongly agreeing that they are satisfied with their work.

Figure 9, below, shows responses to the survey's burnout question, which asks respondents to describe their work situation. The distribution of ratings shows that about 24% of CMHC respondents said they were definitely burning out, their symptoms of burnout will not go away, or they feel completely burned out. Comparatively, about 26% of cohort 1 respondents responded to the question with one of those three responses.

Figure 9: Satisfaction Survey: Burnout at Baseline

These figures provide baseline measures only. However, they reveal many similarities across both CMHCs and primary care practice sites, showing, overall, some level of stress and some evidence of burnout in about 20% of clinicians and staff members. The evaluation will monitor changes over time in these measures to determine whether the CMHCs that are participating in SIM see any improvements in staff and clinician satisfaction or decreases in burnout.

Health Information Technology in CMHCs

Each CMHC has completed a baseline Data Quality Assessment and a follow-up revised Health Information Technology Assessment. These assessment focuses on sites' abilities to report on Clinical Quality Measures (CQMs), HIE connectivity, and telehealth capabilities. The assessments also include notes from the Clinical Health Information Technology Advisor (CHITA) working with the centers.

While these elements are all important components of the overall SIM effort, they apply to CMHCs in different ways. For example, although three of the four CMHCs report telehealth capabilities, telehealth is not a significant component of their team-based care models.

As was the case with the cohort 1 primary care practice sites, CHITA-filed notes reveal that the vast majority of technical assistance activities for the CMHCs during their first year centered around reporting on Clinical Quality Measures (CQMs). None of the centers are focusing on telehealth as a primary method of integrating care. However, three of the four centers do have telehealth capabilities. Of those three, two use telehealth to provide psychiatric services; the third uses telehealth for some psychological counseling services.

Two of the CMHCs report some degree of current HIE connectivity, but field notes do not elaborate on the degree to which these have been useful in current integration or data reporting capabilities.

The CMHCs have challenges—similar to primary care practice sites' challenges—accurately capturing and reporting on CQMs. The centers have prioritized working to determine the workflows needed to ensure accurate recording of data elements as well as ensuring that EHR reporting is accurate. However, the CMHCs have an additional challenge in CQM tracking: All four CMHCs reported that they currently must work with two different EHRs for patient care. This arrangement poses multiple challenges, including the need to create additional workflows (e.g., creating Excel spreadsheets to combine data from two systems, data warehouses for tracking where data are stored, etc.). One center is moving toward an integrated EHR for Spring 2018.

Data Quality for CQM Reporting

Data quality, specific to CQM reporting, is captured in two broad categories. The first category is the ability to accurately record and store specific single data fields (or "**elements**") that are important components of CQM reporting. These elements include fields such as gender, age, BMI, date of a depression screening, etc. The second category is the ability to use those

elements to calculate and report out the actual measure (e.g., percent of patients who receive a depression screening).

Despite the challenges that require workarounds to accurately report on CQMs, each of the centers reports the ability to accurately capture and report data for a high percentage of elements assessed in the SPLIT Data Quality Assessment (now the Health Information Technology Assessment). Figure 10 shows the changes, between May 2017 and January 2018, in the number of data elements that CMHCs report they can consistently capture. Green bars indicate those elements that can be consistently captured; yellow bars indicates elements that are being captured by data systems but are not trusted to be accurate; red bars represent those items that are not captured but could be with changes.

Figure 10: Changes in Ability to Capture Data Elements

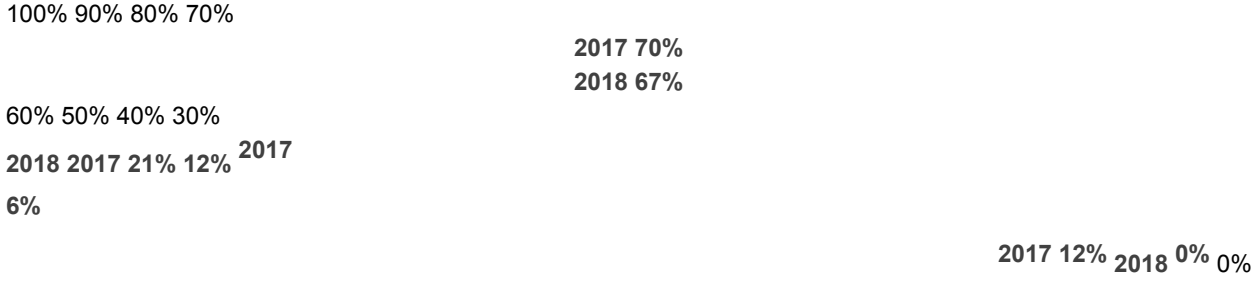
The measures in Figure 10, though similar, are not exact comparisons. Some changes were made to the assessment between 2017 and 2018. The changes to the Data Quality Assessment (now the HIT Assessment) mirrored a refining of CQMs made to ease the reporting burden on practice sites and improve reporting ability. As a result, the total number of individual data elements being reported differed slightly. The small decrease in the chart is evidence of a change in specific elements, not a reduction in sites' abilities to report. The percentage of green elements would have stayed stable

had the assessment not changed.

Figure 11 (next page) shows a similar pattern for the CMHCs' abilities to report on CQMs. While there was some decrease in the number of green items—those items that CMHCs believe they can report on consistently and that they trust the reported results—appears to have decreased slightly. However, this is related to a change in the CQMs being reported on between the two

assessment periods, not a change in ability to report. Note, also, that some CMHCs were initially unable to capture some CQMs (gray bars), but that issue appears corrected.

Figure 11: Changes in Ability to Capture and Report on CQMs



All CMHCs note some difficulty reporting on the two substance use disorder (SUD) measures. Two of the sites have concerns that the number of SUD patients receiving treatment is undercounted as a result of (1) complexities with patient flow between behavioral health and physical health providers (depending on which provider is seen first) and (2) payment issues, depending on how services are billed. One CMHC has higher rates of treatment on these two measures and reports more confidence in its data. That CMHC reports less of an issue related to the behavioral and physical treatment occurring in the same site location. The other sites may benefit from support on how to best report the SUD CQMs, although it is important to note that these measures do not necessarily align well with an individual CMHC's population.

Success Story: Data Driven Improvement Data-driven care is another essential Building Block (#2) designed to drive continuous quality improvement in an integrated health home. At CRC, SIM funding supported the buildout of a comprehensive data warehouse that contains data from CRC and their primary care partner, Salud Family Health Centers. This continues to strengthen CRC's ability to report on key SIM quality measures for health home-enrolled patients and will ultimately support additional data sharing between the partners, such as a single plan of care.

2017 20%
12% 10%

Client Outcomes

CCAR Mental Health Functioning Indicators and Health-Related Quality of Life Indicators

As part of the evaluation of their efforts, each of the four Community Mental Health Centers (CMHCs) funded by SIM is providing data for eight Colorado Client Assessment Record (CCAR)[14] mental health functioning scales. The CCAR scales (see appendix) are being used to rate patient functioning, or the impact of mental health problems on patient functioning. The State of Colorado requires the CMHCs to complete CCARs on people they serve, and the data reported to SIM come from that effort. Eight scales were chosen from a broad set of functioning ratings to provide data most relevant to the SIM effort.

The CMHCs also chose to collect quality of life data and used the Health-Related Quality of Life (HRQOL) instrument from the CDC (Centers for Disease Control)[15] to collect these data for people they serve. The 14-item HRQOL (see appendix) is used to collect data from patients in three areas: healthy days, activity limitations, and symptoms related to those limitations.

Both types of data, CCAR and HRQOL, are collected from patients when they enroll in the CMHCs and then again at six-month intervals thereafter. Data are provided to TriWest twice a year: in March and again in September. The data reported in this section are from the first data submission in September 2017. They include primarily enrollment data and will serve as baseline data. Very little reassessment data were provided and are excluded from this report.

CCAR Mental Health Functioning Indicators (Baseline)

As part of the evaluation of their efforts, each of the four Community Mental Health Centers (CMHCs) funded by SIM is completing eight Colorado Client Assessment Record (CCAR) mental health functioning scales. The CCAR scales (see Appendix) are used to rate patient functioning, or the impact of mental health problems on patient functioning. Table 5 (next page) shows average scores at the time of enrollment (baseline functioning). Additionally, scores are shown in three scoring categories: positive functioning (score 1–4), moderate impact (score of 5), or negative (score of 6–9). Higher scores reflect more concern in each area.

Data were submitted for the first time in September 2017 for patients enrolled in the

SIM- funded CMHCs. As there were limited follow-up data at that time, only baseline data are presented here. As follow-up data become available, it will be important to show how patients

[14] Colorado Department of Human Services, Office of Behavioral Health CCAR Manual, 2016. [15] Center for Disease Control and Prevention Health-Related Quality of Life (HRQOL) web site: https://www.cdc.gov/hrqol/

are improving in these areas. For example, the integration of physical health care into the CMHCs should be expected to result in improvement in the Physical Health functioning area of the CCAR.

Patient ratings on each score were averaged for each CMHC, and the average of the four CMHC scores for each scale is shown in the table. The table presents the scales in order of average scores with the highest functioning “Self-Care/Basic Needs” scale at the top and “Overall Symptom Severity” in the bottom row. The low CMHC average and the high CMHC average are also shown. The ranges show that average CMHC scores are within a range of plus or minus 0.5 points.

Table 5: Average CCAR Ratings Across Centers at Baseline

Baseline Patient CCAR Scales[1]		
Self-Care / Basic Needs	2.7	2.2 3.0
Physical Health	3.3	3.1 3.6
Social Support	3.4	3.1 3.6
Interpersonal Relationships	3.8	3.4 4.2
Involved in Recovery	4.0	3.8 4.2
Overall Level of Functioning	4.2	3.8 4.6
Involvement in Positive Activities	4.2	3.9 4.4

Overall Symptom Severity 4.8 4.5 5.1

The illustration below for the Involvement in Positive Activities ("Activity Involvement") rating explains the three score categories. In the negative category are patients (21%) with ratings of 6 through 9. These patients engage in few, if any, positive activities and none that involve other people. Another 22.1%, as presented in Table 6 (next page), of the patients are involved in positive activities, but these activities only rarely involve others. In the highest scoring category (Positive) are the 56.9% of patients who are involved in positive activities that involve other people and that may be focused on other people and/or the community these patients live in.

Activity Involvement

Extent to which the person participates in positive activities.

1 – High involvement in a variety of positive activities that are self-, other-, and community-

focuse
d.

[16] CCAR Scales ratings are on a scale of 1 to 9 with higher ratings indicating more concerns, issues or severity.

3 – Involvement in a variety of positive activities that involve others.
5 – Involvement in a variety of positive activities that rarely involve others. 7 – Engages in few, if any, positive activities and none that involve others. 9 – No identified positive activities.

Table 6: CCAR Categories Across Centers at Baseline

Baseline CCAR Scales		
Self-Care / Basic Needs	6.2%	7.4% 86.5%

Physical Health 9.0% 18.0% 73.1%

Social Support 11.8% 10.1% 78.1%

Interpersonal Relationships 19.0% 12.8% 68.2%

Involved in Recovery 15.7% 25.3% 59.0%

Overall Level of Functioning 22.2% 22.2% 55.6%

Involvement in Positive Activities 21.0% 22.1% 56.9%

Overall Symptom Severity 27.1% 38.2% 34.8%

Characteristics of CMHC Patients at the Baseline Assessment

The approach used to summarize data for the demographic tables below is the same as approach used above: that is, values for the four CMHCs were averaged. Table 7, below, illustrates that approach as applied to gender. The average percentage for females served in the four CMHCs is 48.2% (an average of the four individual CMHCs). Although the table shows approximately an even split between females and males, the data show that individual centers differ substantially in the percentage of patients served who are female and male. For example, one CMHC served 38.3% females, while another served 61.5% females.

Table 7: Patient Gender Average Across Centers

Patient Gender Average %
Female 48.2%
Male 51.8%

[17] The three scoring categories are positive functioning (score 1–4), moderate impact (score of 5), or negative (score of 6–9). Higher percent reflects more patients.

Table 8 shows patient age. The “Average %” column presents the average percentage of patients, across CMHCs, who are in each age group. As with gender, individual centers differ in the percentage of each age group depending on the population served by the CMHC.

Table 8: Patient Age Average Across Centers

Patient Age Groups	Average %
17 Years & Younger	5.6%
18 to 29 Years	19.1%
30 to 39 Years	22.3%
40 to 49 Years	19.4%
50 to 59 Years	22.6%
60 to 69 Years	9.7%
70 and Up	1.5%

The same approach was used with the percentage of patients who indicated they were Hispanic or Latino and for the race/ethnicity categories (see Table 9, below). As with other demographic characteristics, individual centers differ in the percentage of patients who are Hispanic and identify with specific race/ethnicity groups, depending on the population served by the CMHC.

Table 9: Patient Ethnicity Average Across Centers

Hispanic & Race/Ethnicity Categories	Average %
Hispanic/Latino	
Hispanic or Latino[18]	19.9%

Rac
e

Native Hawaiian/Pacific Isl. 0.1%

Asian American 3.2%

Native American 3.6%

Black/African American 3.9%

Caucasian American 88.6%

[18] More than one could be

selected.

Health-Related Quality of Life Indicators (Baseline)

As part of the evaluation of their efforts, each of the four SIM-funded Community Mental Health Centers (CMHCs) is completing the Health Related Quality of Life (HRQOL). The 14-item HRQOL (see Appendix) is being used to collect data from patients in three areas: healthy days, activity limitations, and symptoms related to those limitations.

Data were first submitted in September 2017 for patients enrolled in three of the four CMHCs. One center had not completely implemented use of the HRQOL at that time but will submit data in the future. As there were limited follow-up data at this first submission, only baseline data are presented here. Patient ratings on each score were averaged for each CMHC, and the average of the CMHC scores for each item is shown in the tables. In addition, the range of CMHC average scores is shown.

Healthy Days

The first section of the HRQOL includes four questions. The first asks patients to rate

their health in general. The next two ask patients how many days their physical and mental health were not good during the previous 30 days. The final question asks how many days poor physical or mental health kept patients from doing their usual activities. The final row in Table 10, below, shows a combined measure of the physical and mental health days in which patient health was not good, with a maximum of 30.

Patients rated their health in general on a 5-point scale from “Excellent” to “Poor” (1 to 5, respectively). For references to specific wording for each item, the HRQOL instrument is included in the Appendix. The 3.3 average rating for the three CMHCs was slightly better than “Good.” The range shows that the lowest CMHC average was 3.3 and the highest was 3.4—a very consistent rating across CMHCs.

Table 10: Healthy Days Ratings Across Centers at Baseline

Health In General	3.3	3.3	3.4
Days Physical Health Not Good	9.5	8.5	11.0
Days Mental Health Not Good	14.6	13.6	16.3
Days Poor Health Kept from Doing Usual Activities	10.6	9.2	11.6
Days Unhealthy (Physical and/or Mental Health not Good)	15.8	13.2	17.9

[19] Average is of valid response.

On average, patients in CMHCs said they had fewer days when their physical health was not good (average of 9.5) compared with their mental health (14.6). Their total days when their physical and/or mental health was not good averaged 15.8, just over 50% of the time during the previous 30 days. They said poor health limited their activities (e.g., self-care, work, or recreation) about 10.6 days on average during the past 30 days. The range for each item was within plus or minus two days.

Success Story: Engaging Patients in Improving Health Outcomes

Building deep partnership and collaboration with patients is an essential Building Block (#5) for practice transformation. At the end of Year 2, Community Reach Center (CRC) formed two Patient Advisory Councils with the support of their Practice Facilitator: one for English-speaking patients and one for Spanish-speaking patients. With these groups in place, CRC is actively developing and implementing decision aids, self-management support tools, and protocols for strengthening patients' roles in their own care. The groups have empowered consumers to see themselves as a driving force in the health home and their own care.

Activity Limitations

The second section of the HRQOL includes five questions about activity limitations. Key results from this section are summarized in Table 11 (next page). The first question asks patients whether they were limited in any way because of any impairment or health problem. The percentage that said yes averaged 55.8% across CMHCs and ranged from 51% to 61.5%.

The second question asked patients to indicate what the single "Major" impairment or health problem was from a list of 13 items (or "Other"). Patients tended to respond to this in different ways; some checked all that applied, and some chose only one. As a result, responses for this question are not summarized here. This item will be discussed with CMHCs to attempt to standardize the way patients respond.

Patients were also asked how long their activities have been limited. On average, patients said they have been limited 3.6 years, with a range of 1.9 years to 4.5 years. However, a substantial percentage of patients had been limited less than one year. Patients limited less than one year ranged from 40% to 77%.

The final two questions asked patients if they need help with personal care needs and/or with routine needs as a result of the impairment or health problem they identified. Fewer patients said they needed help with personal care needs (13.9%), such as eating, bathing, dressing or getting around the house, than needed help with routine needs (39.2%), such as doing everyday household chores, necessary business, shopping, or getting around for other purposes.

Table 11: Activity Limitation Ratings Across Centers at Baseline

Activities limited due to impairment or health problem: % yes	55.8%	51.0%	61.5%
How long limited (in years)	3.6	1.9	4.5
Need help with personal care needs due to limitations: % yes	13.9%	11.5%	18.4%
Need help with routine needs due to limitations: % yes	39.2%	36.0%	42.9%

Symptoms

The third and final section of the HRQOL includes five questions about symptoms related to physical, mental, or emotional problems or limitations patients may have in their daily lives in the past 30 days. These results are summarized in Table 12, below.

For the first question, averaging across CMHCs, patients responded that for about 8.1 days out of the previous 30 days, pain made it hard to do usual activities. The range across the three CMHCs was from 6.9 days to 9.9 days.

The average days patients felt sad, blue, or depressed was 13.3. The average days patients felt worried, tense, or anxious was 15.1. And the average days patients said they did not get enough rest or sleep was 12.5.

Finally, when asked about how many days they felt very healthy and full of energy, patients averaged 8.1 days across CMHCs. The percentage of patients who answered that they felt very healthy and full of energy on no days in the previous 30 ranged from 33.3% to 49%.

Table 12: Symptom Ratings Across Centers at Baseline

Days Pain Made It Hard to Do Usual Activities - Last 30 Days	8.1	6.9	9.9
Days Felt Sad, Blue, or Depressed - In Last 30 Days	13.3	12.3	14.4
Days Felt Worried, Tense, or Anxious - In Last 30 Days	15.1	13.4	16.1
Days Did Not Get Enough Rest or Sleep - In Last 30 Days	12.5	11.8	13.2
Days You Felt Very Healthy and Full of Energy - Last 30 Days	8.1	6.1	9.3

[20] Average is of valid responses. [21] Average is of valid responses.

Clinical Quality Measures for CMHCs

As with the primary care practice sites, each CMHC chose to report on specific clinical quality measures (CQMs). Across the four centers, at least two CMHCs reported on each of the CQMs listed in Table 13, below.[22]

For added context, the table also presents the values for the CMHCs that reported on that measure, along with corresponding Q4 2017 CQM values for the two currently active cohorts of SIM primary care sites (cohorts 1 and 2). Also, the table shows the target reporting rates established for those cohorts. These targets are not expected to be applied to the CMHCs, but they offer some level of calibration. As noted previously, the CMHCs are approaching integration in ways that differ significantly from the practice sites. Also, the "average" values here are for between two and four CMHCs (depending on how many reported), compared to larger numbers of reporting primary care practice sites (anywhere from 5 sites to 75). Furthermore, the CMHCs serve populations that differ considerably from practice site populations.

Given these different aims and populations, the values reported by CMHCs and practice sites are often similar, though the CMHCs tend to perform higher than primary care practice sites in most of the measures (with the exception of the SUD measures).

Table 13: CMHC CQM Reporting Compared to Primary Care Practice Sites

CQM CMHC Cohort 1 Cohort 2 Target (PCPs) Depression 61.2% 55.0% 56.3% 52.2% **Diabetes: Hemoglobin A1c (lower rate desired) 21.7%** 27.7% 28.6% 29.8% **Hypertension 75.4%** 65.1% 71.7% 70.0% **Obesity: Adult 68.3%** 49.8% 63.2% 54.7% **Substance Use, Alcohol, & Other Screening 31.2%** 55.0% 22.8% 9.9% **Substance Use, Tobacco Screening 71.5%** 99.8% 100.0% 92.7% **Substance Use, Alcohol Screening –** 17.9% 20.4% – **Asthma Medication Management 94.1%** 79.5% 79.3% 65.0%

As noted, CMHCs related some concerns with CQM reporting. First, they expressed having lower confidence in the substance use disorder measures. Second, they reported that challenges in accurately capturing measures likely lead to undercounting the population receiving SUD screening and treatment.

[22] If only one CMHC reported on a measure, that measure was not reported here to avoid reporting any individual site data.

Practice sites, on the other hand, reported that Q4 2017 measures were the most trustworthy (even though practice site CQMs were measured using trailing 12-month data). Given this confidence, these Q4 2017 measures will be used to establish baselines, allowing for tracking change over time and for the SIM office to use these values to set targets.

As with the practice sites, establishing baseline and setting targets for CMHCs begins with Q4 values (in this case Q4 2017), even though CMHCs began their work considerably earlier. In looking at earlier reporting periods, as presented in Figure 12 and Figure 13, there is evidence of improving patient outcomes resulting from adjustments that CMHCs made prior to this most recent reporting quarter.

Figure 12: CQM Measures[23]

As shown in figure 12, above, the percentage of patients diagnosed with hypertension whose blood pressure is adequately controlled (<140/90 mmHg) during the time period increased between Q2 and Q4. Also, the percentage of patients with an “obesity” diagnosis who had a documented follow-up plan increased. During the same span, the percentage of patients with a diabetes diagnosis with poorly controlled A1c decreased; however, because a decrease indicates better health, this trend, though moving downward, is actually a sign of desired improvement.

All three measures show changes that indicate improvements for patients (either in their actual health in terms of lower blood pressure and better A1c control, or in having

a health plan to

[23] For CQMs, higher values are generally preferred and signal improvement. However, for "Diabetes: Hemoglobin A1c," lower values indicate improvement.

control obesity). However, it is difficult to determine whether the changes in these measures reflect actual changes in outcomes for patients or simply show improvements in the CMHCs' abilities to report on these measures. Changes are likely a result of both factors.

Success Story: Improving Clinical Outcomes The integrated health home identified patients with diabetes or pre-diabetes who also have a serious mental illness as a key focal point for their clinical care team to address with their SIM Practice Facilitator. Together, they have established a common protocol to best meet this population's needs and established a menu of evidence-based supports that can be tailored to meet individual patient needs. These services include medical support, nutrition and health coaching, and group treatment services. The health home team monitors the impact of these services and broader educational activities on hemoglobin A1c levels and solicits feedback from the patients engaged in this care. Group engagement has been very high, and feedback has been immensely positive to date.

Figure 13: CQM Measures Including SU[23]

Because the CMHCs tend to target a somewhat higher-need population, individuals with serious mental illness, it is slightly surprising to see better screening saturation on some of the CQMs and better health outcomes (for hypertension and diabetes) on others. However, it is important to note that the CMHCs differ in their reporting from the primary care practice sites, which report CQMs for all patients seen in their site in the period, assuming the CQM is relevant to the patients' characteristics, health needs, and conditions. The CMHCs, however, have agreed to their own collective process for determining patient attribution; this process focuses on attributing those patients targeted for specific intervention efforts. This targeted

reporting may, in part, explain why CMHCs show better levels of screenings and health outcomes.

Success Story: Improving Screening Rates

Jefferson Center has continued to screen mothers with the Edinburgh Postnatal Depression Scale and has now expanded depression screening to include other caregivers associated with the new baby. These caregivers are screening using the PHQ9 and are then successfully connected to a continuum of services when appropriate. New fathers have been a key target audience and have been receptive, though in some cases surprised, to see their own mental health as a consideration after the baby is born. This supports building block 2, Data-Driven Improvement, and building block 7, Practice

Screens for Behavioral Health.

Across primary care practice sites and the CMHCs, confidence in the accuracy of Q4 reporting of the CQMs has increased. For that reason, the SIM office will be using Q4 2017 as “baseline” and for setting targets for the CMHCs. However, a trend analysis that includes CQM reporting for earlier time periods indicates that the CMHCs may have demonstrated some improvement in these measures since their actual implementation start.

We recommend that target setting should take this into account and that future analyses of change over time should also consider that the baseline measure may be somewhat artificially inflated.

CMHC Sustainability

One of the most important factors for sustainability for the CMHCs is the development of payment models that support integrated care. The following two breakout boxes feature two specific examples provided by the CMHCs regarding their efforts to move

toward financial sustainability.

Success Story: Sustainability A key goal for the Bi-Directional Integrated Health Homes effort is to better understand the fiscal case for integrated care and begin to build the financial model for sustainability at the practice level. Using SIM dollars, Jefferson Center was able to hire a health economist and a data analyst to conduct an economic analysis of the integrated care work within the health home. The analysis will leverage data from the All Payer Claims Database and illustrate total cost of care for this integrated care model. Hopefully, the analysis will serve as a guide for assessing the fiscal viability of other integrated care efforts around the state.

Success Story : Sustainability SHG is the only site testing an “in-house” primary care model, hiring primary care providers as employees of the agencies rather than pulling from an outside organization. With their Practice Facilitator, SHG has taken on significant technical assistance to improve primary care delivery and improve billing practices. They have worked wth a Certified Medical Coder who has provided great insight into the primary care billing model, payer relationships, and rates. This effort reflects the vision and commitment of SHG leadership to transform care and deliver integrated services in their rural communities, consistent with building block 1.

Summary and Recommendations

The implementation of integrated care in CMHCs provides some unique insights. The first insight results from SIM's bi-directional effort focusing on a smaller number of CMHCs compared to the number of primary care practice sites. This reduced number of CMHCs has enabled ongoing discussion among the centers on topics such as attribution, types of patients, integrated care models, and funding. These issues reveal the need for ongoing technical assistance that may differ from the assistance to the practice sites. Specifically, because the technical assistance of all types must often consider perspectives from other efforts, CMHCs show a need for technical assistance that is simultaneously center-specific while being broader and more complex.

Along with issues related to technical assistance, attribution of patients provides an example of how sharing perspectives and discussing approaches across the CMHCs can result in a slower process with the need for additional assistance. CBHC and the SIM office recognized the need to facilitate a process for deciding which patients to attribute to their SIM efforts. HMA was contracted to work with the CMHCs and helped identify and work through barriers. The dilemma of how to best attribute patients grew from the CMHC bi-directional efforts being part of the larger CMHC efforts to more broadly serve people in their communities. The response to this dilemma focused on whether to attribute a broader patient population that could potentially be served by the centers or to focus on those patients the CMHCs were serving. The centers decided not to attribute a larger number of patients. Instead, they focused on those patients they serve for whom data could be collected for assessment and outcomes. This selection may result in a smaller attribution early in the SIM effort, but attribution should eventually expand.

Furthermore, CMHCs have shown some benefits from the delay in funding, which then delayed official implementation of their efforts. The benefits stemmed from the CMHCs having time to build a knowledge base about implementing integrated care based on lessons learned from the practice site efforts. Primary benefits resulted from refinements to the SPLIT instruments and online assessment process and from the ongoing discussion held between the SIM office and the payers. A specific example of these benefits is the Milestone Activity Inventory being revised into the new Milestone Attestation Checklist (MAC). The MAC provided more structure to the recommended approach of working through the building blocks of integrated care. Payer input was central to the revision of the milestones, which provides insight into what types of work payers expect from providers in alternative payment models.

Finally, most data for this report were baseline data, and summary and analysis have focused on descriptive summaries and some comparisons to cohort 1 practices. Going forward, there is an opportunity to learn more about the CMHCs and how they compare to practice sites. This

may be accomplished by going more deeply into the nature of the efforts, the type of patients served, and the services provided. Along with SPLIT assessment data and CQM data, APCD data will provide an important opportunity for these types of analysis and a better understanding of the centers.

Recommendations

The SIM office has seen the benefits of lessons learned and has recognized the importance of providing technical assistance to practice sites and the CMHCs. That technical assistance has been critical to enabling progress in building the capacity for integrated physical and behavioral health care in primary care settings. The progress made by the CMHCs in completing the building blocks for integration shows that they have benefited from technical assistance and, as discussed below, some of the emerging insights from the effort, once more fully realized, will provide some lessons that will in turn benefit the larger SIM effort.

- One recommendation based on these preliminary data is that the SIM office work with PTOs and CHITAs for the CMHCs to problem-solve how to improve reporting on the SUD treatment measures. In this area, collaborative problem solving across the centers may be beneficial. Because the SIM office allows for alternative methodologies for computing some CQMs (if necessary), there may be benefit to the CHITAs working together to find a method that works for the unique situations of the CMHCs so that these important measures can be tracked over time in the same way across the four centers. One approach worth exploring is considering whether alternative numerator and denominator specifications could help address the unique nature of CMHC structure and populations served. Workflows might also be examined to isolate any (if they exist) issues around recording SUD screenings and treatment in EHRs. As has been discussed, some of the CMHCs have pointed out that these CQMs do not align well with their populations or team-based care models. However, these measures have been identified as

important to SIM stakeholders as they are important to implementing Alternative Payment Models. These are the measures payers have endorsed as important to value-based payment structures.

- Across primary care practice sites and the CMHCs, confidence in the accuracy of Q4

  reporting of the CQMs has increased. For that reason, the SIM office will be using Q4 2017 as "baseline" and for setting targets for the CMHCs. However, a trend analysis that includes CQM reporting for earlier time periods indicates that the CMHCs may have demonstrated some improvement in these measures since their actual implementation start. We recommend that target setting should take this into account and that future analyses of change over time should also consider that the baseline measure may be somewhat artificially inflated.

- As mentioned previously, there are also some emerging insights across each of the four

  CMHCs that, once more fully tested and described, might provide very helpful examples of "best practices" that may inform not only the other SIM-funded centers but also other CMHCs across the state and some of the primary care practice sites.

- The data warehouse being used by two of the CMHCs for shared care planning

  represents an example of creative problem solving to address the common issue of differing EHRs that are currently unable to transmit patient data between them. This model could be a successful solution for primary care practice sites that (1) are working on integration strategies besides co-location and (2) will need to develop shared care plans with external mental health providers. The project is in its early stages but if successful will yield important lessons.

- One center appears to be having some success with engaging new fathers in

  depression screening. This experience may be informative, particularly as the

SIM office begins to more broadly share the Call to Action that includes a focus on male depression. The Jefferson Center may soon be in a position to share in more detail the specific strategies it found successful in conducting depression screening with this important and specific population of men

- Another CMHC has implemented an in-house psychiatric consultation model to solve

the problem of difficulty in scheduling psychiatric appointments. It is unclear whether this model could be useful for primary care practice sites that are struggling to hire behavioral health providers. However, it could be informative for other CMHCs with interest in integrating primary health care.

Many practice sites struggle with billing for behavioral health services. As part of one CMHC's response to struggles with primary care billing, the CMHC has brought in a medical coding specialist (though that position is not funded by SIM dollars). If this approach proves helpful, the SIM office and PTOs may consider exploring whether enlisting the assistance of behavioral health service coding specialists, the Colorado Department of Health Care Policy and Finance (HCPF) specifically around the new Regional Accountable Entity (RAE) structure, could assist primary care practice sites as they work on sustainability of their integration efforts.

Appendix Colorado Client Assessment Record Scales

Tracking Number: _____. Date CCAR Scales Completed: ____ Month ____ Day ____ Year

Assessment Point: Initial/Enrollment 6-Month Reassessment

1-Year Reassessment 18-Month Reassessment Please write in client's age. For gender and Hispanic origin, please check the box next to the choice that applies to the client. For Race, please check all that apply.

Age: _____ Race: Alaska Native

American Indian

Gender: Female Transgender Asian

Male Other Black/African

Native Hawaiian/Pacific Islander Is client Hispanic or Latino? Yes or No White

Rating Instructions: Choose the number between 1 and 9 that represents the current level of concern (within the last three weeks, or issues that are still of concern to consumer and/or clinician) in each domain. Specific definitions are provided for numbers 1, 3, 5, 7, and 9. Even numbers may be used to describe functioning between the descriptions provided. Fill in the circle above the number selected as reflecting the individual's rating.

Physical Health: Extent to which a person's physical health or condition is a source of concern. **Choose One**.

1 – No physical problems that interfere with daily living 3 – Presence of occasional or mild physical problems that may interfere with daily living 5 – Frequent or chronic physical health problems 7 – Incapacitated due to medical/physical health and likely to require inpatient or residential health care 9 – Presence of critical medical condition requiring immediate inpatient or residential health care treatment

Self -Care/Basic Needs: Extent to which mental health symptoms impact a person's ability to care for self and provide for needs. **Choose One**.

1 – Able to care for self and provide for own needs 3 – Occasional assistance required for caring for self and obtaining basic needs 5 – High levels of assistance needed in caring for self and obtaining basic needs 7 – Unable to care for self and obtain basic needs in a safe and

sanitary manner 9 – Gravely disabled and in extreme need of complete supportive care

1

1

Interpersonal: Extent to which the person establishes and maintains relationships with others. **Choose One**.

1 – Demonstrates healthy relationships with others 3 – Some difficulty developing or maintaining healthy interpersonal relationships 5 – Inadequate relational skills resulting in tenuous and strained relationships with others 7 – Markedly impaired relational skills resulting in poor relationship formation and maintenance 9 – Interpersonal relationships are virtually nonexistent

Social Support: Extent to which the person has relationships with supportive people who contribute to recovery. **Choose One.**

1 – Supportive relationships outside of service providers and actively participates in maintaining them 3 – Supportive relationships outside of service providers 5 – Only meaningful relationships with service providers and others receiving services 7 – Only meaningful relationships with service providers 9 – No meaningful relationships (or relationships that are not constructive) and person wants or could clearly

benefit from
them

Overall Symptom Severity: Rate the severity of the person's mental health symptoms. **Choose One**.

1 – No symptoms are present for this person 3 – Symptoms may be intermittent or may persist at a low level 5 – Symptoms are present which require formal mental health professional intervention. 7 – Significant symptoms affecting multiple domains exist, often requiring external intervention 9 – Symptoms are profound and potentially life threatening

Activity Involvement: Extent to which the person participates in positive activities. **Choose One**.

1 – High involvement in a variety of positive activities that are self-, other-, and community-focused 3 – Involvement in a variety of positive activities that involve others 5 – Involvement in a variety of positive activities that rarely involve others 7 – Engages in

few, if any, positive activities and none that involve others 9 – No identified positive activities

1

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1

1

Overall Level of Functioning: Extent to which the person is able to carry out activities of daily living, despite the presence of mental health symptoms. **Choose One**.

1 – Functioning well in most activities of daily living 3 – Adequate functioning in activities of daily living 5 – Limited functioning in activities of daily living 7 – Impaired functioning that interferes with most activities of daily living 9 – Significantly impaired functioning; may be life threatening

Overall Recovery: Extent to which the person is involved in the process of getting better and developing/restoring/maintaining a positive and meaningful sense of self. **Choose One**.

1 – Views self positively with the knowledge that setbacks may occur and is able to actively pursue and access resources to support recovery, with a sense of empowerment and hopefulness about future outcomes. 3 – Hopeful about future outcomes and is actively participating and using resources to promote recovery 5 – Expresses hopefulness about future outcomes and is willing to begin to engage in using available resources to

promote recovery. 7 – Expresses a mixture of hopefulness and hopelessness about future outcomes and is interested in discussing

available options and resources to aid in recovery 9 – Entrenched in symptoms, expresses hopelessness about future outcomes, and does not actively engage in

using available resources that might promote

recovery

1

Health-Related Quality of Life

Tracking Number: _____. Date HRQOL Completed: ____ Month ____ Day ____ Year

Assessment Point: Initial/Enrollment 6-Month Reassessment

1-Year Reassessment 18-Month Reassessment Thank you for taking the time to fill out this survey. We would like you to take a few minutes to tell us about your health. This will help us know if our services are helping you. Please write in the client's age. For gender and Hispanic origin, please check the box next to the choice that applies to the client. For Race, please check all that apply.

Age: _____ Race: Alaska Native

American Indian

Your Gender: Female Transgender Asian

Male Other Black/African

Native Hawaiian/Pacific

Islander

Are you Hispanic or Latino? Yes or No White

Healthy Days

1. Would you say that in general your health is: Excellent Very Good Good Fair Poor Don't know/Not sure

2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

_____ Number of Days None Don't know/Not sure

3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? _____ Number of Days None Don't know/Not sure

If both 2 and 3 above = "None," skip the next question (question 4).

4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

_____ Number of Days None Don't know/Not sure

Activity Limitations

These next five questions are about physical, mental, or emotional problems or limitations you may have in your daily life.

5. Are you LIMITED in any way in any activities because of any impairment or health problem?

Yes No Don't know/Not sure

If 5 above = "No," please go to question 10.

6. What is the MAJOR impairment or health problem that limits your activities? Please choose one.

Arthritis/rheumatism Back or neck problem Fracture, bone/joint injury Walking problem Lung/breathing problem Hearing problem Eye/vision problem Heart problem Stroke problem Hypertension/high blood pressure Diabetes Cancer Depression/anxiety/emotional problem Other impairment problem Don't know/Not sure

7. For HOW LONG have your activities been limited because of your major impairment or health problem? Please write in the number of days, weeks, months, or years.

_____ Days _____ Weeks _____ Months _____ Years

Don't know/Not sure

8. Because of any impairment or health problem, do you need the help of other persons with

your PERSONAL CARE needs, such as eating, bathing, dressing, or getting around the house?

Yes No Don't know/Not sure

9. Because of any impairment or health problem, do you need the help of other persons in handling your ROUTINE needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

Yes No Don't know/Not sure

Healthy Days Symptoms

These last five questions are about physical, mental, or emotional problems or limitations you

may have in your daily
life.

10. During the past 30 days, for about how many days did PAIN make it hard for you to do your

usual activities, such as self-care, work, or
recreation?

_____ Number of Days None Don't know/Not sure

11. During the past 30 days, for about how many days have you felt SAD, BLUE, or DEPRESSED?

_____ Number of Days None Don't know/Not sure

12. During the past 30 days, for about how many days have you felt WORRIED, TENSE, or

ANXIOU
S?

_____ Number of Days None Don’t know/Not sure

13. During the past 30 days, for about how many days have you felt you did NOT get ENOUGH

REST or
SLEEP?

_____ Number of Days None Don’t know/Not sure

14. During the past 30 days, for about how many days have you felt VERY HEALTHY AND FULL

OF
ENERGY?

_____ Number of Days None Don’t know/Not sure