Instructions to join the meeting remotely:

1. Open a web browser and enter URL: www.readytalk.com
   Enter participant access code: 2093166

2. Phone in for the audio portion of the conference:
   1-866-740-1260 - then enter the access code: 2093166

MEETING HANDOUTS:
www.cchap.org/pmmmeeting
State Innovation Model (SIM): Successes and New Opportunities for Practices

MEETING HANDOUTS:
www.cchap.org/pmmeeting
SIM is helping Colorado practices integrate behavioral health and primary care and test value-based payment models.
Goal: Improve the health of Coloradans by providing access to integrated physical & behavioral health care services in coordinated systems, with value-based payment structures, for 80% of Colorado residents by 2019.
80% of Coloradans have Access to Integrated Care

Payment Reform
Develop and implement value-based payment models that incent integration and improve quality of care

Practice Transformation
Support practices as they integrate behavioral and physical health care and accept new payment models

Population Health
Engage communities in prevention and education, and improve access to integrated care

HIT
Promote secure and efficient use of technology across health and non-health sectors to advance integration and improve health

Consumer Engagement  Policy  Workforce  Evaluation
Primary Care Practices: Integration of physical and behavioral health care in 400 primary care practices over the four-year award period.

Cohort 1: Initial 100 practices on-boarded

Cohort 2: Additional 150 practices on-boarded

Cohort 3: Additional 150 practices on-boarded
- CPC Practices: 32
- School Based Health Centers: 3
- Residency Programs: 5
- FQHCs or Look-Alikes: 20
**Practice Participation Payments**
Each practice participating in SIM is eligible to receive $5,000 in participation payments, over a two-year period, for attending collaborative learning session, participation in evaluation, and reporting on clinical quality measures.

**Regional Health Connectors**
Each SIM practice will be matched with a Regional Health Connector, who will serve as a dedicated resource for connecting the practice to relevant local resources.

**Grants to Practices**
Each practice can apply for competitive small grants of up to $40,000 to offset initial costs of integration.

**Alternative Payment Models**
Each practice will be supported with value-based payments from at least one of the seven payers that signed the SIM MOU.

**Practice Facilitators and CHITAs**
Each SIM practice is matched with an approved Practice Transformation Organization that provides them with a Practice Facilitator (PF) and/or Clinical Health Information Technology Advisor (CHITA), as well as other technical assistance.

**Business Consultation**
MGMA provides resources and assistance to help practices improve business processes and accept alternative payment models.
82% of survey respondents stated that they would recommend participation in SIM to a colleague and/or other practice.

Responses to an open-ended item regarding advantages and value that SIM offered practices were as follows:
- Networking
- Increased focus on integrated behavioral health
- Optimized use of EHR
- Structured goal setting
- Grants and funding access
RFA Anticipated in February

RFA Administered by University Department of Family Medicine

Apply: https://www.colorado.gov/healthinnovation/cohort2
COHORT 2 - TIMELINE

Recruitment
Jan - March 2017

Selection
April - June 2017

Enrollment
July - Aug 2017
### KEY CHANGES

<table>
<thead>
<tr>
<th>Feedback</th>
<th>Change to RFA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting burden</td>
<td>Streamlined set of Clinical Quality Measures</td>
</tr>
<tr>
<td>Difficulties implementing SIM at individual practice sites instead of across groups/systems</td>
<td>All practices in a group/system now encouraged to apply</td>
</tr>
<tr>
<td>Confusion regarding support from payers</td>
<td>Inclusion of clarifying language with links to the payer MOU, addendum, and payment model summaries in RFA</td>
</tr>
<tr>
<td>$5,000 insufficient and practices said the $40,000 grant applications were difficult</td>
<td>Achievement-based payments of up to $13,000 will be available/grant funds will exclusively be provided via The Colorado Health Foundation</td>
</tr>
<tr>
<td>Insufficient HIT support</td>
<td>Inclusion of HIE support in RFA, more clearly defined information regarding broadband expansion</td>
</tr>
</tbody>
</table>
• Ongoing work to better define CHITA role
• Implementation of quality assurance process
• SPLIT re-development and enhancement
• Multiple efforts to further build the PTO learning community
RFA includes revised sets of Practice Transformation Building Blocks - one for adults and one for pediatrics

Building Blocks represent a unified set of payer priorities

Payers have identified Building Blocks 1-4 and 7 as priorities

Will solicit workgroup feedback on how to operationalize and implement
# Colorado SIM Practice Transformation Framework (Pediatric)

The Colorado SIM initiative aims to improve health outcomes for all Coloradans by ensuring that high-quality whole person care includes behavioral health. The initiative assumes that in order to effectively integrate behavioral health and primary care, practices and payers must fundamentally transform the way care is financed and delivered. Participating Colorado payers already have in place alternative payment models (APMs) that support primary care transformation. For SIM, participating payers have payment options for behavioral health integration based on the SIM building block framework (see Appendix A). Payers’ existing APMs are already tied to outcomes measures at each plan, and payers are working through the Multi-Payer Collaborative to align their measures in support of behavioral health integration.

For SIM, practices are expected to work through the building blocks, and maintain “good standing” with the behavioral health focus of the initiative through successful achievement of specific building block metrics, as outlined below. If practices are not in good standing with SIM, payers will individually determine the impact to their programs. The SIM office will work with SIM transformation organizations and the University of Colorado, Denver to support transformation and to determine practices’ standing. Practice standing information will be shared with payers to inform eligibility for SIM payment structures. “Good standing” is defined as the following for each project year:

- **Project year 1**: Practices must achieve building blocks 1 through 4 and 7 (as measured by Year 1 metrics)
- **Project year 2**: Practices must achieve building blocks 1 through 4 and 7, and two additional building block (as measured by Year 2 metrics)

<table>
<thead>
<tr>
<th>BUILDING BLOCK</th>
<th>GOAL</th>
<th>YEAR-1 METRICS</th>
<th>YEAR-2 METRICS</th>
</tr>
</thead>
</table>
| 1 Practice has engaged leadership, supportive of integration and change | Practice establishes agreement(s) with payer organization(s) that cover at least 150 patients across payers, for value-based payment program(s) to support practice transformation under SIM. | • Practice establishes agreement(s) with payer(s) covering at least 150 patients.  
• Practice has completed an annual budget that includes SIM revenue and planned expenses.  
• Practice develops QI team and meets monthly.  
• Leadership present at meetings and clinical champion attends learning collaboratives.  
• Practice has vision for behavioral health integration, and has identified a pathway for behavioral health transformation signed by leadership. | • Leadership allocates appropriate resources to complete quality improvement (QI) work.  
• Practice designs plan to evaluate impact of value-based payment agreements. |
| 2 Practice uses data to drive change | Practice uses EHR clinical quality measures to provide quarterly panel reports on all SIM measures not extracted through claims data; uses claims data provided through a data aggregation tool to inform QI processes. | • Practice successfully submits ecQMs quarterly.  
• Practice reviews data with practice facilitator (PF)/Clinical Health Information Technology advisor (CHITA) quarterly.  
• Practice begins using model for improvement and has identified opportunities for improvement using ecQMs data.  
• Practice begins using a data aggregation tool to review cost and utilization data. | • Practice reviews ecQMs and data from data aggregation tool to inform rapid cycle improvement processes.  
• Practice develops processes for providing performance feedback to providers, including ecQMs, cost, and utilization data.  
• Practice conducts regular PF/QI activities on identified ecQMs. |
| 3 Practice population is empaneled | Practice has, and maintains, at least 75% of its patient population empaneled. | • Practice has assessed patient panel and assigned primary care provider/patient teams to 75% of patient population.  
• Practice reviews payer attribution lists monthly.  
• Practice designs and implements process for validating primary care provider/patient team assignment with patients. | • Practice maintains 75% empanelment of patient population to provider or care teams.  
• Practice develops policies to support empanelment, including definitions, changing FCPS, assigning new patients, and ensuring continuous coverage. |
<table>
<thead>
<tr>
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</table>
| 4 Practice provides team-based care | The care team uses shared operations, workflows, and protocols to facilitate collaboration and consistently implements specific shared workflows rather than informal processes for at least three measures, including at least one behavioral health measure. | • Practice uses established tool to assess baseline team relationship.  
• Practice has written job descriptions.  
• Practice identifies and implements a team-based care strategy (e.g., team huddle, collaborative care planning). | • Practice reevaluates team relationship using tool from Year 1.  
• Practice develops protocols for shared workflows for three quality measures (with at least one behavioral health measure).  
• Practice performs task distribution activity to inform development of team-based care PAs/Ps. |
| 5 Practice has built partnership with patients | Practice has established use of evidence-based shared decision-making aids or self-management support tools for at least one, preference-sensitive condition, and tracks the use of these tools.  
Practice has established a patient and family advisory committee (PFAC) to provide input and feedback on practice transformation activities and progress. | • Practice evaluates patient population to identify one preference-sensitive condition that would be appropriate for decision-aids or self-management support tools.  
• Practice identifies and selects evidence-based decision-aids or self-management support tools for identified conditions.  
• Practice has established a PFAC and meets at least quarterly. | • Practice identifies patients/families that are eligible for selected decision aids or self-management support tools.  
• Practice implements decision aids or self-management support tools and establishes protocols and workflow for use.  
• Practice develops process for tracking and evaluating use of decision-aids or self-management support tools.  
• Practice uses PFAC to evaluate care experience. |
| 6 Practice is actively managing patient population using data | Practice uses population-level data to manage care gaps, develop care management care plans and institute those plans for high-risk patients/families. | • Practice identifies strategy to identify care gaps (e.g., patient registry, data aggregation tool) and prioritize high-risk patients/families. | • 75% of high-risk patients/families have a documented care plan.  
• Practice implements proactive care gap management and tracks outcomes.  
• Practice embeds care plan template in EHR. |
| 7 Practice has linked primary care to behavioral health and social services | Practice screens at least 90% of appropriate patients/families for substance use disorder and/or other behavioral health needs, and includes behavioral health and community services as part of care management strategies. | • Practice has identified behavioral health resources for patients/families, including health plan support from SIM participating plans.  
• Practice has implemented a screening tool for reporting on at least two of the five behavioral health screening measures: SIM (depression, maternal depression, anxiety, substance use disorder and developmental screening) and screens at least 25% of patients.  
• Practice has documented process for connecting patients/families with behavioral health resources (from screening), including standing orders and protocols and follow-up. | • 50% of patients are screened for behavioral health condition(s).  
• Practice performs an assessment of community resources to assist patients/families with social needs (such as food, housing, transportation).  
• 50% of patients identified with behavioral health need are connected to resource. |
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</thead>
</table>
| 8 | Practice provides prompt access to care, including behavioral healthcare | Practice, at a minimum, has established collaborative care management agreements with behavioral health providers in the community and members of the care team can articulate how to use those agreements. Clinical data based on collaborative care management agreements with behavioral health providers is able to be shared bi-directionally within 7 days. | • Practice has representative with EAR access available 24 hours, 7 days per week.  
• Practice performs an assessment of referral pathways and available after-hours support for behavioral health.  
• Practice identifies data sources and technology necessary for bi-directional data sharing. | • Practice has established a collaborative agreement with at least one behavioral health provider.  
• Practice develops plan for bi-directional data sharing with behavioral health provider. |
| 9 | Practice provides comprehensive care coordination for primary and behavioral healthcare | Practice has reduced total cost of care while maintaining or improving quality of care for patients, including those with anxiety, depression, and substance use disorders compared with non-SIM practices. | • Practice can identify total cost of care for patient panel, and subset of patients with behavioral health condition.  
• Practice identifies and implements policy and procedures that included timely follow-up for ED and hospital admissions. | • Practice contacts 50% of patients within 7 days of hospitalization or ED visit, including medication reconciliation.  
• Practice identifies cost drivers for patients with behavioral health condition and incorporates in QI processes.  
• Practice creates and reports a measurement to assess impact and guide improvement on at least one of the following:  
1. Notification of ED visit in timely fashion  
2. Medication reconciliation process completed within 72 hours  
3. Notification of admission and clinical information exchange at the time of admission  
4. Information exchange between primary care and specialty care related to referrals |
| 10 | Practice has fully integrated behavioral healthcare to provide whole-person care | Patient behavioral health outcomes are systematically measured over time and treatment is adjusted as needed, as measured by outreach, registry and other information readily available for purpose of monitoring and adjustment. | • Practice has identified and documented referral pathway for behavioral health needs (including assessment of referral pathways and available after-hours support for behavioral health and a representative with EAR access available 24 hours, 7 days per week).  
• Practice develops a plan to systematically measure and track patient behavioral health outcomes.  
• Practice develops care plans that include patient/family actions to manage behavioral health conditions. | • Practice systematically measures and tracks patient behavioral health outcomes.  
• Practice documents and implements protocols to manage care provided to identify high-risk behavioral health populations.  
• Practice identifies and implements at least two opportunities to adjust its protocols to improve behavioral health status of patients. |
<table>
<thead>
<tr>
<th>Measure Condition</th>
<th>SIM Metric Title</th>
<th>Citation</th>
<th>CPC+</th>
<th>QPP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary CQMs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan</td>
<td>NQF 0418 CMS 2v6</td>
<td>Depression Remission at 12 Months</td>
<td></td>
</tr>
<tr>
<td>Diabetes: Hemoglobin A1c</td>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
<td>NQF 0059 CMS 122v5</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Controlling High Blood Pressure</td>
<td>NQF 0018 CMS 165v5</td>
<td></td>
<td>✓</td>
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<tr>
<td>Obesity: Adult</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan</td>
<td>NQF 0421 CMS 69v5</td>
<td>No obesity measure (not required for SIM if in CPC+)</td>
<td>✓</td>
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<tr>
<td>Substance Use Disorder: Alcohol and Other Drug Dependence</td>
<td>Initiation &amp; Engagement of Alcohol &amp; Other Drug Dependence Treatment</td>
<td>NQF 0004 CMS 137v5</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Substance Use Disorder: Tobacco</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>NQF 0028 CMS 138v5</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Secondary CQM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>Medication Management for People with Asthma <em>(replaced to align with QPP)</em></td>
<td>NQF 1799 CMS n/a</td>
<td>No asthma measure</td>
<td>✓</td>
</tr>
<tr>
<td>Fall Safety</td>
<td>Falls: Screening for Future Fall Risk</td>
<td>NQF 0101 CMS 139v5</td>
<td></td>
<td>✓</td>
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<tr>
<td>Maternal Depression</td>
<td>Maternal Depression Screening</td>
<td>NQF 1401 CMS 82v4</td>
<td>No maternal depression measure</td>
<td>✓</td>
</tr>
<tr>
<td>Substance Use Disorder: Alcohol</td>
<td>Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling</td>
<td>NQF 2152 CMS n/a</td>
<td>Alcohol &amp; Other Drug Dependence measure <em>(above)</em></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Measures reported via APCD claims data automatically</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Breast Cancer Screening</td>
<td>NQF 2372 CMS 125v5</td>
<td><em>(clinical)</em></td>
<td>✓</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>Colorectal Cancer Screening</td>
<td>NQF 0034 CMS 130v5</td>
<td><em>(clinical)</em></td>
<td>✓</td>
</tr>
<tr>
<td>Measure Condition</td>
<td>Metric Title</td>
<td>Citation</td>
<td>QPP</td>
<td></td>
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<tr>
<td><strong>Primary CQM</strong></td>
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</tr>
<tr>
<td>Depression</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan</td>
<td>NQF 0418 CMS 2v6</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Development Screening</td>
<td>Developmental Screening in the First Three Years of Life <em>(developed by Mathematica)</em></td>
<td>NQF 1448 CMS – under development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Depression</td>
<td>Maternal Depression Screening</td>
<td>NQF 1401 CMS 82v4</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Obesity: Adolescent</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>NQF 0024 CMS 155v5</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Secondary CQM</strong></td>
<td></td>
<td></td>
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<tr>
<td>Asthma</td>
<td>Medication Management for People with Asthma <em>(replaced to align with QPP)</em></td>
<td>NQF 1799 CMS n/a</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
# CLAIMS-BASED MEASURES

## Cost of Care and Utilization
- Total Cost of Care
- Out of Pocket Expenditures for Consumers
- Admissions
- Psychiatric Admissions
- Readmissions
- Psychiatric Readmissions
- Emergency Department (ED) Rate
- Psychiatric ED Rate
- Follow-up after Hospitalization for Mental Illness

## Access to Care
- Prevention Quality Chronic Composite
- Prevention Quality Acute Composite
- Pediatric Quality Overall Composite
- Prevention Quality Overall Composite
THANK YOU!

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