HEALTH Transformation IN COLORADO: how SIM can Leverage and Support Colorado’s Healthy Spirit
VISION - To create a coordinated, accountable system of care that will provide Coloradans access to integrated primary care and behavioral health in the setting of the patient’s medical home.

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.
A team of primary care and behavioral health clinicians, working together with patients and families, providing patient-centered care for a defined population.

May address mental health and substance abuse conditions, health behaviors, life stressors and crises, stress-related physical symptoms.
PARTICIPATION QUALIFICATIONS

- Colorado primary care practice
- Leadership commitment to move toward behavioral health integration
- Electronic health record (EHR) in place
- Experience with practice transformation, including team based care, quality improvement, population management and using data for improvement
- Financial acumen to be able to adapt to new payment models
- Rural: 33
- Pediatrics: 22
  - Mixed Pediatrics: 8
- Hospital/System owned: 26
- FQHC: 18
- Residency: 6
- School-based clinics: 5
- Underserved population: 47
Work on advancing behavioral health integration using an advanced primary care model.

Form a SIM Implementation Team, generally at least a provider champion, a clinical support staff member, a front desk person, the office manager, and, if applicable, a care manager and/or behavioral health professional.

Submit clinical quality measures at least quarterly.

Send at least two people to two, day-long learning sessions per year, held regionally across the state.

Participate in the SIM evaluation process.
AchEIVements Expected

▪ Individualized by practice - depending on starting point and resources available

▪ Advance on the continuum of high performing primary care

▪ Advance on the continuum of achieving behavioral health integration within which ever model: coordinated, co-located; integrated
Coordinated Care: Behavioral and primary providers practice in different locations, but collaborate and coordinate care by having preferred provider referral sources with opportunities for communication between settings.

Co-located Care: Both types of providers deliver traditional outpatient behavioral health and medical care separately but their offices are housed in the same location.

Integrated Care: Behavioral health and primary medical care providers share patients/caseloads and develop treatment and care plans together, consult on a real-time basis while the patient is being seen at the clinic setting, and provide integrated care as a team.
Figure 1a. High-Performing Primary Care

PRACTICE ROLES

Category 3: Integration

Category 2: Advancement and Evolution

Category 1: Foundation Building

KEY COMPETENCIES FOR EACH STEP OF HIGH-PERFORMING PRIMARY CARE

<table>
<thead>
<tr>
<th>Assessment Name</th>
<th>Purpose</th>
<th>Who Fills It Out</th>
<th>Responsible for Reporting</th>
<th>Timing</th>
<th>Expected Time to Complete (Minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Home Practice Monitor</td>
<td>Practice self-assessment of level of implementation of core aspects of advanced primary care</td>
<td>Practice team led by PF</td>
<td>Practice Champion</td>
<td>Baseline &amp; every 6 months</td>
<td>60</td>
</tr>
<tr>
<td>IPAT</td>
<td>Assesses current methods BHI along levels of coordination, co-location and integration</td>
<td>Practice champion</td>
<td>Practice Champion</td>
<td>Baseline &amp; annually</td>
<td>10</td>
</tr>
<tr>
<td>Clinician and Staff Experience Survey</td>
<td>Individual provider and staff survey that assesses two subscales – Clinician and Staff Experience and Burnout</td>
<td>All members of Practice</td>
<td>Each practice member</td>
<td>Baseline &amp; annually</td>
<td>15</td>
</tr>
<tr>
<td>SIM Milestone Activity Inventory</td>
<td>Assesses practice's current implementation of SIM milestone activities, helps identify gaps and prioritizes practice's next steps</td>
<td>Practice team led by PF</td>
<td>Practice team submits draft, PF submits final</td>
<td>Baseline &amp; every 6 months</td>
<td>60</td>
</tr>
<tr>
<td>Data Quality Assessment</td>
<td>Assesses practice's current state of data quality including accuracy of data element capture, validity of CQM reports and desired next steps for HIT</td>
<td>Practice HIT champion led by CHITA</td>
<td>CHITA</td>
<td>Baseline &amp; every 6 months</td>
<td>60</td>
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<tr>
<td>Practice Improvement Plan</td>
<td>SMART goals related to practice transformation as it relates to milestone activities. Can be done at same time as inventory</td>
<td>Practice team led by FF</td>
<td>PF</td>
<td>Baseline &amp; every 6 months</td>
<td>15</td>
</tr>
<tr>
<td>Clinical Quality Measures</td>
<td>Track patient and process outcomes reported by practices</td>
<td>Practice champion</td>
<td>Practice Champion</td>
<td>Every calendar quarter starting Q2 2016</td>
<td>Variable</td>
</tr>
</tbody>
</table>
- Transforming Clinical Practice Initiative
  - Practice support for primary care and specialists
  - Psychiatry is an excellent opportunity to align with SIM
  - Training for psychiatrists in “Collaborative Care Model”
    - Promotes psychiatrists working through PCPs, care managers, etc.
    - Opportunity to enhance access to psychiatry without the need for one on one.
THANK YOU!

The Project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the US Department of Health and Human Services, Centers for Medicare and Medicaid Services.