

Part IV. Project Narrative

A. Introduction

The concept of hot-spotting has captivated health policy circles since *The New Yorker* magazine published Atul Gawande’s seminal piece, “The Hot Spotters: Can we lower medical costs by giving the neediest patients better care?”¹ Identifying small populations that account for a disproportionate amount of health spending, time, and resources, has proved to be an effective way of lowering costs, providing appropriate care and improving the patient experience.

What happens when a state considers hot-spotting on a larger scale? Colorado’s State Innovation Models proposal will answer this question through its proposed project, Colorado SHIFT: Statewide Health Innovations Fostering Transformation. At a statewide level, Colorado SHIFT will address specific high-cost, high-risk sub-populations that can be better managed through person-centered coordinated care. Colorado SHIFT also develops statewide infrastructure, including data and payment reform components in the private and public sector, to support the health care delivery system throughout its transformation to integrated care. The primary sub-population Colorado SHIFT aims to address are those individuals who have co-occurring physical and behavioral health issues necessitating a higher level of coordinated care. Better care for these individuals not only means better health and better care for them, but also lower costs for the health system overall. As discussed in Colorado’s State Health Care Innovation Plan, our focus on physical-behavioral health integration is just a starting point for a more comprehensively integrated health system that includes physical and behavioral health, public health, oral health, and long-term services and support.

Colorado is well-suited and prepared to test this model. Our recent health policy history is founded on innovation and collaboration. Our investments in patient-centered medical homes

¹ Gawande, A. The Hot Spotters: Can we lower medical costs by giving the neediest patients better care? *The New Yorker*, Jan. 24, 2011.

and broader health communities provide us with a solid foundation from which further innovation can thrive. We have a history of collaboration among payers, among providers, among advocates, across the legislative aisle, and with philanthropic organizations.

B. State Health Care Innovation Plan Testing Strategy

1. Purpose of the Model

The purpose of Colorado SHIFT is to test whether behavioral health can be successfully integrated into primary care practices across the state by bringing together several components required for successful integration. These include operational, clinical, financial, and technological changes at the practice, regional, statewide, and system levels. For purposes of this project, behavioral health includes mental illness and substance abuse, with the recognition that because these conditions often present long-term challenges for individuals, clinical interventions should mirror those related to prevention and treatment of chronic conditions.

Untreated behavioral health issues and chronic diseases are the source of many poor health outcomes and are drivers of avoidable health care costs. These challenges are compounded when patients present with multiple chronic conditions, either physical or behavioral. These health epidemics are related, both to one another and to morbidity, mortality, and the cost of traditional “sick treatment” health care, whether chronic or acute. Managing multiple chronic conditions requires patients to navigate a fragmented health system that produces unsatisfying and expensive outcomes for patients, avoidable suffering, premature death, and generally inefficient care. Opportunities to find ways to best care for this large subset of the patients routinely seen in primary care remains one of the most vexing challenges and promising opportunities for health care policy. Colorado is confident that a person-centered,

individualized approach will make the difference in providing patients with what they want and need, while also saving money and improving population health outcomes.

The goal of Colorado SHIFT is to reconcile the delivery system's fragmentation by transforming primary care practices into competent first-line providers of comprehensive, integrated care. Colorado will activate the process of system transformation by better addressing the needs of persons with multiple chronic conditions and by promoting prevention. Colorado is also looking to impact integration and population behavior. Pockets of innovators in Colorado have focused on these problems and have changed how they do business to better serve their patients. Conveners and systems thinkers in Colorado have thought deeply about how to support and replicate these innovations. For the purpose of this funding opportunity, over one hundred of these leaders came together, and this proposal distills the best of their ideas.

Colorado SHIFT aims to transform the health care delivery system as a whole, but has the integration of behavioral health as the prime lever of action. There is evidence in the literature that shows the efficacy of primary care-directed interventions on positive patient experiences, lower cost of care, and better population health. In efficient health care systems, primary care serves an organizing and integrating function, with a strong influence on patient consumption patterns through referral and counseling. Primary care serves as a cornerstone of the health delivery system, with downstream impacts on all other sectors, which is why Colorado SHIFT focuses on primary care, but it recognizes that the broader system also needs reengineering. Because Colorado is already recognized as a national leader in effective primary care service delivery, this strategy builds on these prevailing strengths. Colorado can demonstrate rapid results under the short timeframe of this funding opportunity, and results from testing in Colorado have the potential to be replicated nationwide.

2. Scope of the Model

Colorado SHIFT proposes to test and fund three complementary and mutually reinforcing strategies. First, Colorado proposes to invest in data, measurement, and payment infrastructure. Effective integration is not possible without accurate and timely data, common measurements, and payment structures that reward coordination. Included in this proposal are a number of investments in data, metrics, and payment systems that have the potential to “change the measuring stick” that currently defines success in health care delivery.

Second, Colorado proposes to expand and leverage existing structures for learning and communication in the health care system. Colorado SHIFT will develop “Learning Collaboratives” to disseminate current best practices broadly throughout the health care community, focused on, but not exclusively limited to, primary care providers and teams. These supports will “push the envelope” by advancing innovative efforts in continual process improvement and reform.

Third, Colorado proposes to provide funding for practices to finance the cost of and enhance integration. Colorado has significant clinical experience integrating physical and behavioral health care through numerous innovations; however, financially sustaining these efforts remains a challenge and a priority. Transforming primary care practice is a difficult and work-intensive endeavor with substantial cost, both in terms of lost productivity during transition and through financial investment in coaching, new tools, processes, and staff. We will partner with other national and state efforts around financial sustainability including the Colorado Health Foundation which has funded Sustaining Healthcare Across integrated Primary care Efforts (SHAPE), a multi-payer (public and private) project to identify sustainability for integrating behavioral health and primary care.

3. Model Description, Delivery System, and Payment

To achieve Colorado SHIFT's goal of improving integrated care, Colorado will better support integration clinically, operationally, and financially at two levels: 1) regional and 2) practice level. Existing regional organizations and private payers participating in the CMMI-funded Comprehensive Primary Care Initiative (CPC Initiative) will provide support to local practice sites that are awarded supplemental funding to develop structural capabilities. The initial primary care practice sites for Colorado SHIFT will be current participants in Colorado Medicaid's Accountable Care Collaborative (ACC) and current participants in Colorado's CPC Initiative. (Note: a complete Glossary of Terms can be found on page ii of the Colorado Health Care Innovation Plan.)

This approach creates a continuum within which practices, Regional Care Collaborative Organizations (RCCOs), and other entities can develop integration practices that fit their unique communities and populations. This framework creates a path to guide entities toward more sophisticated integration.²

a. Regional Level Supports

The ACC will be the foundation and infrastructure of Colorado SHIFT for Medicaid populations. Approved by CMS and implemented in May 2011, the ACC is highly similar to the federal Accountable Care Organization model. The two central goals of the ACC are (1) to improve health outcomes of Medicaid clients through a coordinated, client-centered system, and (2) to control costs by reducing avoidable, duplicative, variable and inappropriate use of health care resources.

² A graphic of the ACC/RCCO model showing geographic crossover of CPC Initiative practices can be found on page 9 of the Colorado Health Care Innovation Plan.

The ACC divided the state geographically into seven regions, with each region managed by a RCCO. The RCCOs are contracted to ensure care management services as appropriate to clients and to develop provider networks in the region. Colorado SHIFT builds upon this structure and enhances the role of the RCCOs to provide additional practice supports to improve integrated care. Specifically, participating RCCOs will be responsible for developing and administering provider trainings relating to integrated care; providing enhanced practice transformation support and guidance, including practice cultural readiness for integration; and conducting an assessment on the readiness of primary care practices to participate in the project as an integrated care site. The RCCOs may also define additional requirements for participating primary care providers beyond the minimum criteria.³

Colorado SHIFT will also engage private payers in this regional approach. We will use the experience of RCCOs that are private payers to inform other regions about the best mechanisms to engage payers in delivery system conversations.

b. Practice Level Supports

At the community and practice level, Integrated Primary Care Providers (IPCPs) participating in the ACC or the CPC Initiative may apply to participate in the statewide integration initiative as a single IPCP or as a group with other providers. The partnering RCCO will work with IPCPs to develop a community plan agreed upon by local stakeholders, in which Colorado SHIFT resources are aligned to promote integration and behavior change interventions. Interventions may occur within the practice and in the community, particularly for patients who require outreach and extended support in non-clinical settings and between visits.

³ Providers in the ACC have traditionally been referred to as Primary Care Medical Providers (PCMPs). Through Colorado SHIFT, we will transition to the term Integrated Primary Care Provider (IPCP) and we use this term throughout the proposal.

Certain support structures are necessary for the application of integrated behavioral health and primary health care in practice. Colorado has developed a conceptual framework and strategic path for integration based on these prerequisites. Entities will be assessed on their current sophistication of data usage and other layers of operational readiness that reflect upon their ability to effectively integrate care for better patient outcomes and satisfaction while containing costs.

The RCCO, private payers, and Colorado SHIFT will assess the practice using the following criteria, which includes stages of data use and operational readiness.

Figure 1.0: The Stages of Data Use

Stage 1:	Practice has an existing approach or plan to exchange data (within the specified timeframe) between primary care and behavioral clinicians or it can explain how it will collect the data.
Stage 2:	Practice is using data in treatment decisions and to affect clinical outcomes.
Stage 3:	Practice is using data to measure total cost of care and readiness to operate within a prospective budget/payment.
Stage 4:	Practice is using data for population health, including sharing data with public health agencies, etc.

Participating practices will be required to have in place or develop a data strategy including standard elements defined by Colorado SHIFT, such as functionality that allows them to monitor performance for process and clinical outcomes and submit de-identified or summary data to the evaluation team. This functionality may be part of a practice’s Electronic Health Record (EHR) software, or it may require additional technology supports to allow information to be sent to the right "box" either inside or outside the organization.

Colorado has also adopted a practice readiness scale to help practices assess their organizational capacity for integration of physical and behavioral health. Recognizing that practices will be at various stages of “readiness to change,” the scale will allow Colorado SHIFT

to maximize the learning community platform and connect practices to others at the same stage of change of operational readiness. The operational readiness scale will also allow Colorado SHIFT to adopt strategies to help practices regardless of where they are with their readiness to integrate. For example, if a practice is at a “0” on the scale, the state can offer educational materials for better integration and connect the practice to others that have successfully integrated. Colorado SHIFT will use the following questions to identify where a practice is along the operational readiness continuum:

Figure 2.0: Integration Operational Readiness

1. Are behavioral health professionals onsite?
 Yes No Don't know
 If no, the practice must have a plan on how they are going to integrate or address patients with behavioral health conditions. SKIP TO QUESTION #3
2. Are behavioral health professionals 'integrated' in that they work with, communicate, and collaborate with other providers in the primary care clinic?
 Yes No Don't know
3. Does the practice consistently identify/screen patients for mental and behavioral health needs?
 Yes No Don't know
4. Does the practice have a standard approach to using the data it collects through screening and monitoring to reflect on how it is doing with care delivery, and to make improvements and adjustments on an ongoing basis, as needed?
 Yes No Don't know
5. Can the practice collect and track patient outcomes for the identified mental and behavioral health conditions?
 Yes No Don't know
6. Among the patients with a mental or behavioral health issue identified, and when referral is appropriate, can engagement in services be tracked?
 Yes No Don't know
7. Can patient initiation be tracked?
 Yes No Don't know

# Answered "Yes"	Stage	Level
0	Stage 1	Preparing
1-2	Stage 2	Start up
3-4	Stage 3	Operational
5-6	Stage 4	Advanced
7	Stage 5	Seamless

Since operational readiness in and of itself is only one step, this tool will be used to connect practices with appropriate payment mechanisms.

Each participating IPCP will develop a workplan toward integration that will be updated periodically throughout the funding period. Workplans for Colorado SHIFT will be integrated

flexibly and non-duplicatively into existing workplans, progress reports, and timelines that have already been imposed by either CPC Initiative, SHAPE, private payers, or other federal transformation projects. The work plans will be approved first by the RCCO and then by Colorado SHIFT.

Changing practice is hard. Integrating behavioral health into primary care goes beyond simple clinical integration, but also requires practices to adjust operationally. Accommodating new mechanisms to detect for behavioral health, developing new skill sets to treat the identified behavioral health conditions, and engaging new providers can necessitate a difficult culture shift for both primary care and behavioral health providers. Therefore, Colorado SHIFT will create a robust learning collaborative network that can address many of these issues, discussed below.

c. Payment Reform

Payment reform is a necessary component to make Colorado SHIFT investments and interventions sustainable and effective. Colorado SHIFT is based upon three principles: Global Budgeting, Cost Accountability, and Provider Payment Reform. Payments to providers will be designed to ensure sufficient risk-adjusted reimbursement, giving providers the time and capacity needed to perform clinical interventions, as well as the planning, panel management, and coordination activities required for effective integrated care.

We do not propose only one payment structure for Colorado SHIFT. Instead, a range of payment models will be available to funded entities based on their level of operational readiness for integration. For example, a provider at Stage 1 of operational readiness is unlikely to be able to effectively accept a comprehensive global payment. As providers move along the operational readiness scale towards greater integration, payment methodologies will also change.⁴ This

⁴ A comprehensive description of Colorado's future payment methodologies can be found in Strategy #3 of the Colorado Health Care Innovation Plan, beginning on page 33.

allows Colorado SHIFT to use payment reform as a tool rather than an end in itself, by enabling primary care providers and their local provider networks to achieve progressively greater impacts on the total cost of care and population health.

Within the ACC, licensed insurance entities with risk-based capital reserves, such as Rocky Mountain Health Plans and Colorado Access, are participating in several regions as RCCOs. These entities are already capable of accepting global payments from Medicaid or offering as a private payer, and they are working to structure and layer finely targeted, private contractual arrangements in a manner that maximizes cost accountability for IPCPs and other participating providers without transferring excessive financial risk to undercapitalized entities. Likewise, in other areas, providers will be paid directly by Medicaid through hybrid models (e.g., Fee-For-Service plus care coordination payments, ambulatory sub-capitation) according to their operational readiness.

Maximizing public-private partnerships within the ACC aligns with several similar payment reform initiatives underway within commercial insurance plans. Given Colorado's statewide designation as a CPC Initiative site, private payers and Medicare have formally committed to providing enhanced, non-volume, non-encounter, and risk-adjusted payment to 73 advanced primary care practices. This infusion of financing in primary care will compliment the community partnerships established within the ACC and accelerate Colorado SHIFT objectives set forth in this proposal.

d. Learning Collaborative Model

One key to improving health care quality is to reduce unnecessary variation in care across practice environments while consistently advancing and incorporating evidence-based strategies. Acknowledging that providers often develop unique strategies to integrate care based on their

operational infrastructure and the needs of their community, cross-practice learning collaboratives are one supported method to exchange best practices, share knowledge on an ever-expanding evidence base, and improve upon methods used in the clinical environment. Learning collaboratives bring together groups of clinicians, practices, patient advocates, agencies, and community and public health leaders to work together to improve one or more areas of health care.

Colorado SHIFT's learning collaboratives will be modeled off of past successful health care initiatives in the state, and experienced primary care practices will act as mentor practices to others just beginning their transformation. Practice coaches will also assist IPCPs to improve areas such as patient access, patient satisfaction, crisis management, chronic and preventive care, electronic medical record use, person-centeredness, cultural competence, and team building. The geographically affiliated collaboratives will decide on content and provide geographically-appropriate discussion. Online discussions, webinars, teleconferences, and e-newsletters will share regional learning across the statewide community, and collective experiences statewide will help the state assess workforce needs required for integration and for adequate access to primary, behavioral, and specialty care.

Colorado SHIFT staff will be responsible for the learning collaboratives, data collection and analysis, and overall facilitation of technical assistance to regions and practices. Each region will have a designated technical assistance team to assist practices within its geographic boundaries, although all practices experiencing transformation in different regions will also be connected through the learning collaborative model. Colorado SHIFT staff will also convene day-long sessions to address pertinent topics and challenges in establishing integration processes. Industry experts will give keynote presentations alongside Colorado SHIFT experts who can

share practical experience. The sessions will allow time for attendees to network with peers from other practices, exchanging information and advice.

Colorado is fortunate to be a site for seven projects that received CMMI Innovation Challenge funding, five of which are focused on integrating physical and behavioral health care (see below, Section 7b on page 22). Thus, they create ideal “learning laboratories” for our efforts to better coordinate care and will be included in our learning collaboratives over the course of the grant period.

e. Example Project for Funding

Colorado has identified an early innovator for a Colorado SHIFT project. This organization is one of the RCCOs in the ACC, Rocky Mountain Health Plan, and has submitted a proposal to integrate behavioral health with primary care in their region. The RCCO, the Behavioral Health Organization (BHO), two Community Mental Health Centers (CMHCs), a physician group, and a regional hospital have proposed to partner using new contractual arrangements for the provider payment. This group will provide leadership, capital, data production, project governance, and cost accountability for the region. The risk-sharing and governance components of the early innovator project will be implemented between the commercial payer and the CMHCs, with support from the BHO. Behavioral health integration will be demonstrated at the clinical level and at the financial, system leadership, and governance levels. For this early innovator site, providers will be accountable for the total cost of care, supported by internal and external feedback reporting, with proportionate exposure to missed cost targets, and bonuses for achieving prospective budget objectives. There will also be a bonus opportunity for quality improvement, independent of budgetary targets.

The goals of the early innovator project are to maximize the reciprocal integration of behavioral and primary care services; deploy a new community workforce to support behavior change interventions in non-encounter settings between visits; accelerate provider payment reform through targeted private agreements; align cost accountability, risk-based capital and local governance; and achieve a positive impact upon the cost of care for the entire population below 250% FPL – approximately 120,600 Coloradans.

If funded, Colorado SHIFT will require other regions, practices, or payers to propose similar types of initiatives along the continuum of integrated care and payment methodologies. Several large private payers in Colorado have expressed support for this concept.

f. Data Integration Strategy

An essential component of Colorado SHIFT is the data integration strategy, which will support the clinical adoption of integrated practices and population health strategies, the standardized measurement of quality metrics and impact analyses, and payment reform efforts.

Practice-Level Data Strategy.

In order to participate as an IPCP in Colorado SHIFT, practices will be required to submit a data strategy. Payment reform will be tied to practices' ability to collect data and show the impact of their integration efforts, and data strategies will demonstrate a practice's ability to comply with state-established standards facilitating interoperability and the collection and use of clinical information by multiple payers. Collectively, this information will provide support and infrastructure for long-term payment reform.

Participating IPCPs will also be required to be able to send and receive secure messages compliant with Nationwide Health Information Network (NwHIN) Direct standards and transport protocols. Through NwHIN Direct-compliant exchange, health care providers will be

able to securely share patient information such as referral requests, care summaries, and test results through a basic messaging service that supports compliance with privacy and security requirements for the exchange of sensitive behavioral health data. Finally, participating IPCPs must adopt EHRs (as defined by the Office of the National Coordinator for Health Information Technology) and must achieve and maintain Meaningful Use. This requirement ensures that all providers participating in Colorado SHIFT have the base-level functionality to capture and utilize patient clinical information in a manner compliant with national standards and industry best practices.

Technical Support

Implementation of Colorado SHIFT necessitates some technical work to support sound data collections that underlay Colorado's Health IT infrastructure. Activities include identifying data requirements, establishing baseline metrics, and working with Health IT stakeholders to develop specific performance measures and to identify and fill gaps in existing data sources. Colorado SHIFT funds will be used to invest in information technology systems and assistance to facilitate implementation care coordination and bundled and global payments.

g. Quality Measures

The state will employ a multi-level quality measurement strategy. As much as possible, quality measures will align with existing measures for current initiatives in the state, including ACC and CPC Initiative measures. With the CPC Initiative's emphasis on CMS's Adult Medicaid Core Measures, there is already widespread agreement on an initial set of common measures, but these may need adjustments to support the behavioral health focus of Colorado SHIFT. Colorado will convene stakeholders impacted by the interventions implemented under the SIM grant and would occur during the initial six month implementation period. Achieving

consensus around specific metrics used to measure progress and ensure accountability is absolutely necessary for realizing stakeholder buy-in and generating support for the initiative.

Colorado SHIFT metrics will inform analysis of the total cost of care on both a PMPM and total population basis, patient satisfaction, quality outcomes, cost savings associated with specific payment and delivery system interventions, and total cost savings for both public and private sector payers. For purposes of Colorado SHIFT, the metrics must be able to reflect both state and system-wide impacts on broad segments of population, as well as impacts on individual target populations, geographic areas, or communities that are the focus of service delivery and payment reform efforts.

4. Objectives and value proposition of the model

Colorado SHIFT addresses four main objectives: (1) to test the outcomes of regionally-developed models for integrated primary care and behavioral health care; (2) to improve care, patient satisfaction, and health outcomes and reduce costs for people with co-occurring behavioral and physical health conditions by using an integrated, person-centered approach; (3) to use prevention and early intervention strategies to affect the behaviors and improve the future health of people who may otherwise develop behavioral and/or physical health conditions; and (4) to develop the necessary statewide data and payment infrastructure to support the most effective models of integrated care into the future. This approach will result in better care and lower costs by increasing access to behavioral care for at-risk populations and minimizing inappropriate emergency department usage.

5. Evidence Basis for the Model

Colorado's own innovations have provided considerable evidence to the national literature demonstrating quality improvement and cost savings through medical homes, integrated care, and learning collaboratives.

a. Medical Homes

Colorado is an established leader in ensuring children with Medicaid and the Child health Plan *Plus* (CHP+) have access to a medical home. The Colorado PCMH Pilot for Children, operating in partnership with CDPHE since 2007, has resulted in increased family satisfaction, preventive care services, care coordination, and cost savings, as shown in the following table:

Metric	Children not Enrolled in PCMH	PCMH for Children Enrollees
Age 0-20 receiving at least one immunization per year (2007-2010)	14.45%	56.7%
Annual per capita pharmacy costs (2010 only)	\$275.00	\$251.00
Annual Emergency Department visits (2010 only)	Range: 1-54 visits	Range: 1-22 visits
Hospital admissions (Anthem BCBS, 2007-2010)	18 % increase over period	18% decrease over period
Emergency Department visits (2007-2009)	NA	13% decrease compared to control group
Inpatient admissions for multiple comorbidities (2007-2009)	NA	Approximate 1/3 decrease compared to control group

The ACC was developed through lessons learned from the Medicaid PCMH for Children Pilot. Initial results from twelve months of risk-adjusted data in the ACC show trend decreases in 30-day hospital readmissions and emergency room visits when compared to 2011 rates. These decreases have been realized through many different types of efforts, including physician practice redesign; high-cost, high-needs case management; health information exchange; and client and physician reminders. Ongoing performance reporting by the practices has helped providers hone skills in identifying the needs of the population and in providing feedback.

Coordinated care in the behavioral health setting has also shown evidence of success. In the past twelve years, the number of members enrolled in Colorado behavioral managed care plans has increased substantially, from approximately 150,000 in 1997 to 510,000 in 2010. As the number of enrolled members has more than tripled, BHO plans have been able to minimize their rate increase from approximately \$35 PMPM in 1997 to only \$37 PMPM in 2010. This rate of increase is far less than the rate experienced by health care costs overall. BHO leaders largely attribute this relatively flat cost curve to a shift toward community alternatives, early identification, and prevention. While controlling costs per member, the BHOs have also increased access to care. The number of members receiving care has increased more than four-fold from almost 17,000 in 1997 to nearly 68,000 in 2010.⁵

b. Integrated Care

The integrated care model is based on much evidence. A number of studies have demonstrated that people with multiple chronic conditions are among the most challenging and most expensive patients in the healthcare system.^{6,7,8} Care for patients with multiple medical problems that include a behavioral health component presents additional challenges because of historical fragmentation of the health care system separating mental health services from other components of health care.^{9,10} The results are unsatisfying and expensive, and have generated avoidable suffering, premature death, and inefficient care. Current interest in redesigning primary care presents an important opportunity to change the system, especially for primary care

⁵ Altarum Institute. Colorado Behavioral Health Organizations Bend the Cost Curve While Increasing Access to Care for Medicaid Beneficiaries. June 2011.

⁶ Ani C, et al. Comorbid chronic illness and the diagnosis and treatment of depression in safety net primary care settings. *J. Am. Board Fam. Med.* March 2009, 22(2):123-135.

⁷ Lurie IZ, Manheim LM, Dunlop DD. Differences in medical care expenditures for adults with depression compared to adults with major chronic conditions. *J. Ment. Health Policy Econ.* Jun 2009, 12(2):87-95.

⁸ Wagner EH, Austin BT, Von Korff M. Organizing care for patients with chronic illness. *Milbank Quarterly.* 1996;74:511-544.

⁹ Donaldson MS, et al., eds. *Primary Care: America's Health in a New Era.* Washington, D.C.: Institute of Medicine, 1996 (citing deGruy F., Mental health care in the primary care setting).

¹⁰ Regier DA, et al. The de facto US mental health and addictive disorders service system: Epidemiologic catchment area prospective. *Archives of General Psychiatry,* 1993; 50:85-94.

patients with behavioral health problems in addition to or as part of other medical problems.^{11,12}

Multiple systematic reviews have demonstrated the effectiveness of integrating mental health services delivery into the primary care setting, and although much research focuses on depression, there is a broad spectrum of needs for which behavioral health interventions are necessary.^{13,14,15}

c. Learning Collaboratives & Practice Coaching

Learning collaboratives, an important part of Colorado SHIFT, are the key to successful improvement statewide.^{16,17} Learning collaboratives have become a widely-used strategy to bring about change in primary care practices and in healthcare, and are supported by the Institute for Healthcare Improvement for their effectiveness.^{18,19} Additionally, practice coaching (or practice facilitation) assists physician practices to improve areas such as patient access, chronic and preventive care, electronic medical record use, patient-centeredness, cultural competence, and team-building. Practice coaches collaborate closely with practices to make improvements grounded in the science of improvement. Practice coaching helps staff develop the capacity for sustained change and improvement.²⁰ State and regional models like HealthTeamWorks in

¹¹ American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint principles of the patient-centered medical home. 2007; available at: <http://www.medicalhomeinfo.org/Joint%20Statement.pdf> (accessed September 21, 2012).

¹² Petterson S, Phillips B, et al. Why there must be room for mental health in the medical home. *American Family Physician*. 2008; 77(6):757.

¹³ Blount A. Integrated primary care: Organizing the evidence. *Families, Systems, & Health*, 2003 (Summer); 21(2), 121-133. 2003.

¹⁴ Craven M, Bland R. Better practices in collaborative mental health care: An analysis of the evidence base. *Canadian Journal of Psychiatry*. 2006 (May);51.

¹⁵ Butler M, Kane RL, McAlpin D, et al. Integration of Mental Health/Substance Abuse and Primary Care No. 173. Agency for Healthcare Research and Quality (publication no. 09-E0003); October 2008.

¹⁶ Berwick D. Continuous improvement as an ideal in health care. *N. Engl. J. Med.* January 5, 1989; 320(1):53-56.

¹⁷ Crabtree BF, Miller WL, Aita VA, Flocke SA, Stange KC. Primary care practice organization and preventive services delivery: a qualitative analysis. *J. Fam. Pract.*. May 1998;46(5):403-409.

¹⁸ Kilo CM. A framework for collaborative improvement: lessons from the Institute for Healthcare Improvement's Breakthrough Series. *Qual Manag Health Care*. Sep 1998;6(4):1-13.

¹⁹ Plsek PE. Collaborating across organizational boundaries to improve the quality of care. *Am. J. Infect. Control*. Apr 1997;25(2):85-95.

²⁰ Grumbach K, Bainbridge E, Bodenheimer T. Facilitating Improvement in Primary Care: The Promise of Practice Coaching. The Commonwealth Fund. June 2012.

Colorado affirm the belief that most practices cannot undertake needed transformation without such a mechanism in place.

6. Theory of Action and Expected Impact

The underlying theory of action behind Colorado SHIFT is that by first providing support for primary care practices, we assist them in transforming into high functioning, person-centered medical homes, and therefore they provide better behavioral health and primary care integration and care management supports at the point of care. Colorado SHIFT will partner collaboratively with providers, behavioral health and health plans to 1) compile data necessary to create an accurate stratification of the population, 2) align interventions with population needs continuously across each strata, 3) link the actuarial value of the interventions at each strata with accountability in the governance model and sustainability.

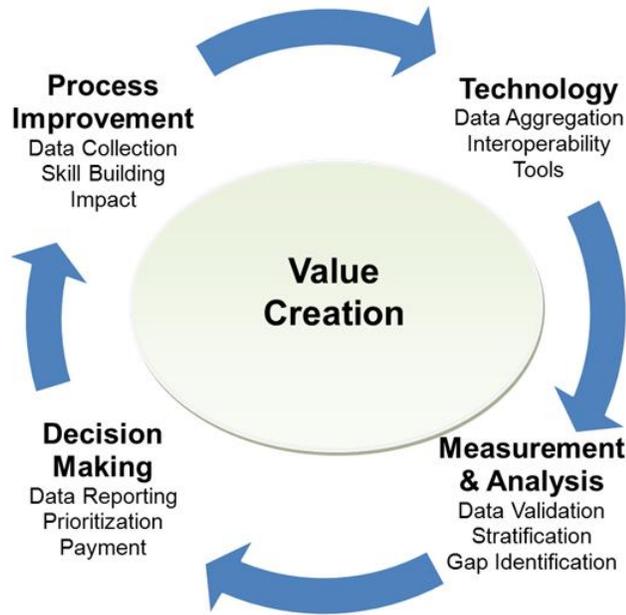
In addition to expanding capacity within primary care, Colorado SHIFT's theory of action turns upon the data-driven alignment of interventions across stratified population health risks and determinants. The logic model set forth below, which is predicated upon the *Four Quadrant Model*,²¹ illustrates how Colorado SHIFT participants will prioritize, align and integrate intervention activities with patient risks and needs:

²¹ Barbara Mauer, Behavioral Health and Primary Care Integration: Models, Competencies and Infrastructure. National Community Behavioral Health Council, May 2003.

	Quadrant 1	Quadrant 2	Quadrant 3	Quadrant 4
Diagnostic Complexity	Low Physical / Low Behavioral	Low Physical / High Behavioral	High Physical / Low Behavioral	High Physical / High Behavioral
Heightened Risks	Accident, Disease, Disability	Accident, Disease, Disability, Major Event / Mortality	Major Event / Mortality	Major Event / Mortality
Patient Characteristics	Not Diagnostically Complex Higher Functional Ability	Major Psych Diagnosis Lower Functional Ability	Major Physical Diagnosis Lower Functional Ability	Major Physical and Psych Co-Morbidities, Lowest Functional Ability
Frequent Confounding Factors	Unhealthy Behavior Lower-Scale Depression Chronic Pain Substance Abuse	Unhealthy Behavior Chronic Pain Substance Abuse Isolation Difficulty Utilizing Primary Care	Unhealthy Behavior Lower-Scale Depression Chronic Pain Substance Abuse	Unhealthy Behavior Chronic Pain Substance Abuse Isolation Difficulty Utilizing Primary Care
Clinical Focus	Behavior Change Pain Management Addiction Disorder	Care Coordination Medication Adherence Behavior Change Pain Management Addiction Disorder Primary Care Access	Care Coordination Medication Adherence Behavior Change Pain Management Addiction Disorder	Care Coordination Medication Adherence Behavior Change Pain Management Addiction Disorder Primary Care Access
Time Horizon for Outcomes	Longer Term	Longer Term	Near Term	Near Term
Planned Interventions	Depression Screening Substance Abuse Screening Motivational Interviewing Patient Coaching Pain Protocols	Trans-disciplinary Case Mgt Substance Abuse Screening Patient Coaching Navigator Services Pain Protocols	Trans-disciplinary Case Mgt Depression Screening Substance Abuse Screening Motivational Interviewing Patient Coaching Pain Protocols	Trans-disciplinary Case Mgt Substance Abuse Screening Motivational Interviewing Patient Coaching Navigator Services Pain Protocols
Additional Coordinated Therapy (When Necessary)	Substance Abuse Treatment Short-Term Therapy	Substance Abuse Treatment	Substance Abuse Treatment Short-Term Therapy	Substance Abuse Treatment
Diagnostic Complexity	Low Physical / Low Behavioral	Low Physical / High Behavioral	High Physical / Low Behavioral	High Physical / High Behavioral

Note that many of the patient risks and “confounding factors” are continuous across all strata of the logic model. Working simultaneously at all population levels is necessary not only to mitigate multiple chronic conditions, but also prevent the development of future disabilities for patients with lesser diagnostic complexity who are nonetheless significantly at risk due to behavior and other factors. Colorado SHIFT will not be another exercise in the deployment of disease-centric care management programs. Rather, the logic model will facilitate the efficient use of resources and the accurate, actuarial valuation of the impact of the planned interventions upon trends in the cost of care for each population segment.

Further, Colorado SHIFT will be designed to continuously promote the improvement of value within the health care system. Resources, competencies, and roles will be aligned to promote the objectives and value propositions of the model, as shown in the graphic below:



The allocation of SHIFT funding shown in the proposed budget comports with the need for investment in all four domains of this continuous improvement model.

7. Other Federal Initiatives

a. Colorado Beacon Community

The Western Colorado community has come together to support a Beacon Communities Cooperative Agreement with ONC. Over the past two years, a collaborative leadership structure sponsored by Rocky Mountain Health Plans, Quality Health Network (QHN), Mesa County Physicians Independent Practice Association, St. Mary’s Hospital, Regional Medical Center, and Club 20 (a prominent regional business and civic leadership group that represents 20 counties) has come together to promote two core objectives: the expansion of HIE Services and broad-based practice transformation in 51 independent primary care sites.

The Colorado Beacon demonstration has produced significant, longitudinal improvements in practice-based quality measures over validated baselines in several domains of Meaningful Use. Additionally, the regional HIE has interfaced with all 12 hospitals operating within the region and is now demonstrating powerful new tools for population health

management in primary care settings. The most significant aspect of the Colorado Beacon demonstration, however, is that the tools, collaborative learning, and quality reporting processes have been implemented across multiple, independent (and often competing) care delivery sites on a community basis, without the “corporate control” required in most integrated delivery systems. Colorado Beacon’s work will therefore provide the foundation for the sustainability of the reforms contemplated in Colorado SHIFT.

b. Innovation Challenge projects

Colorado is the home of seven projects receiving CMMI Innovation Challenge funding. While these projects are focused on individuals in public health programs, lessons from these approaches can also inform efforts in the commercial insurance sector. Colorado’s Innovation Challenge projects centering on behavioral health are detailed in the following table:

Innovation Challenge Projects Related to Behavioral Health	Colorado Connection
COMPASS (Care of Mental, Physical and Substance Use Syndromes)	Kaiser Permanente Colorado is local partner for multistate initiative led by Institute for Clinical Systems Improvement
Sustainable High Utilization Team Model	Serves low-income populations in Denver suburbs
Tipping Point	Lead organization is Southeast Mental Health Services, serving rural Colorado
21 st Century Care	Lead organization is Denver Health
Colorado Community Treatment Centers	Lead organization is the Feinstein Institute for Medical Research

c. Pioneer ACO

PHP, a network of integrated practice associations of primary care physicians in metro Denver, was one of 32 entities nationwide selected to participate in CMMI’s Pioneer ACO program. PHP’s model focuses on creating medical homes, providing care resources, and managing patient care in hospital systems, specialists, and community resources for more than 28,000 Medicare patients. While the Pioneer ACO is designed to improve care and control costs for Medicare, PHP practices also contract with commercial payers, providing the opportunity to

consider how to adapt the ACO coordinated care approach for commercially-insured populations. PHP will be included in the Colorado SHIFT learning collaboratives.

d. Money Follows the Person

Colorado is currently implementing an LTSS project with funding from MFP. Long-term care providers and case managers help create smooth transitions when individuals move from nursing homes and psychiatric hospitals into the community. Part of an effective transition is integrated behavioral and physical health care, and Colorado SHIFT participant sites will provide this support. Because LTSS are not included in Colorado SHIFT's scope of work for this funding period, there will not be a duplication of effort or expenditures. Instead, Colorado SHIFT staff will work at the systems level to collaboratively align efforts with MFP, and RCCOs will work to coordinate community-based providers.

e. The Colorado Telehealth Network

CTN provides broadband connections for Colorado's healthcare delivery systems that facilitate a seamless, statewide broadband telecom network of over 200 physical and behavioral health care providers in rural and urban areas. In the next 18 months, CTN will leverage an anticipated \$20 million in new federal funding to increase its current connections to 500 providers. Going forward, CTN will expand its value by providing videoconferencing in addition to affordable broadband access, which will support tele-behavioral health. CTN's efforts support Colorado SHIFT participant providers and safety net medical providers by facilitating transfer of data, medical images, and electronic health records to achieve greater integration of physical and behavioral health care in communities statewide.

8. Sustainability Plan

The key to long-term sustainability and replicability of Colorado SHIFT is demonstrating measurable impacts on cost from its new delivery and payment approaches for both Medicaid and privately-insured populations in order to adopt them as permanent features of the state's health care system. Medicaid will be able to demonstrate that integration and associated payment reforms improves population health and provides cost savings to the state budget. Commercial payers will be able to show similar improvements to the employer purchasers that fund employee benefit plans. Only with such evidence of meaningful return on investment will both state legislatures and employer purchasers be willing to invest in these approaches in the long term.

In order to create this return on investment, it is essential to have carefully designed evaluation mechanisms, timely feedback data to participating practices that will enable them to effectively manage care, initial practice coaching and support to facilitate the transition to new delivery and payment models, and feedback loops and learning collaboratives to enable participating practices to learn from colleagues and improve.

In addition, commercial payers must be able to implement these new delivery and payment models without the need for significant changes to benefit design. While such changes may be helpful over the long term, initial adoption will be easier if payers can do so within their existing coverage and cost-sharing structures. That is why implementing Colorado SHIFT within the construct of the medical home is crucial—it is a design that commercial payers have already embraced and retooled their systems to accommodate.

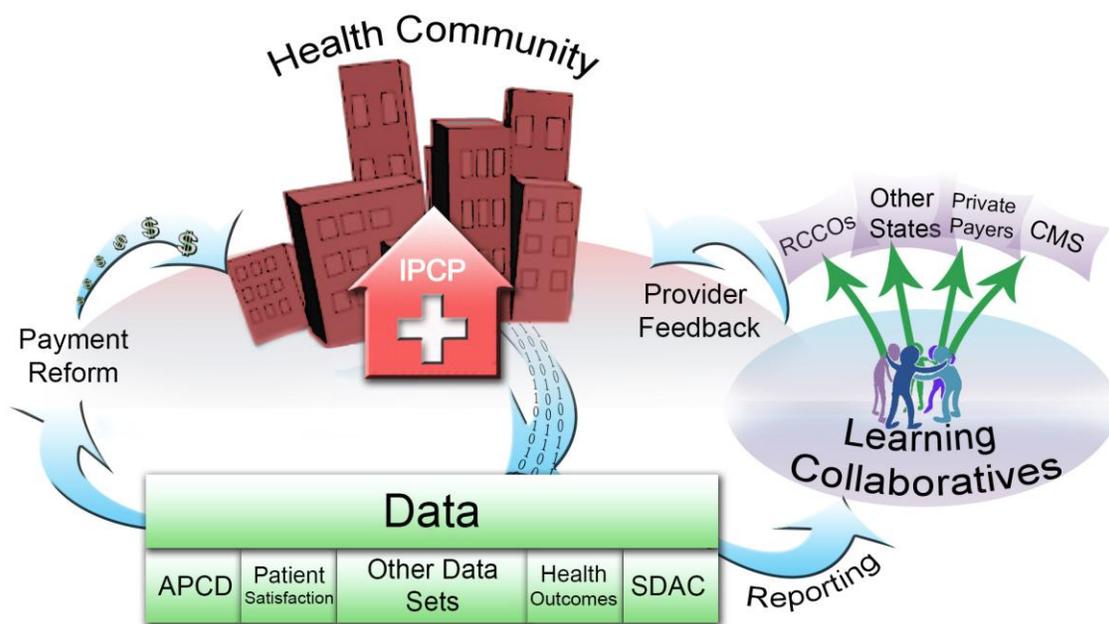
Another key to long-term sustainability is access to data. Colorado's approach leverages existing data and invests in additional data and information initiatives to support assessment of accountability and performance at the statewide, or system level. This includes an investment in significant planning and implementation efforts to improve comparability across data sets.

Through Colorado SHIFT, resources will be secured to conduct analysis and planning of how health-related data sets can be linked, combined, or compared through the Colorado Information Marketplace, including significant efforts to define necessary data governance controls (e.g., HIPAA-HITECH compliance) and establish specific implementation plans for priority data sets.

9. Replicability Potential for Other States

The model provides an appropriate balance between local flexibility for innovation and statewide consistency to ensure quality. With proven PCMH models at the core of the proposal and statewide support structures through the ACC and learning collaboratives, the model will be replicable to other practices and geographic regions. The graphic below not only illustrates the basic infrastructure of the model within Colorado, but also how this information will be shared with a broader audience and how it can support replicability outside of Colorado:

Colorado SHIFT System Overview



10. Focus Communities

Colorado SHIFT is designed to be a statewide initiative, implemented throughout Colorado using the existing infrastructure of the ACC regional model, supported by additional non-ACC practice participants and private payers.

11. Success and Risk Factors

We believe that Colorado's likelihood of success with Colorado SHIFT is high. As noted by CMS in the Funding Opportunity Announcement, the greatest risk factors are:

a. Stakeholder engagement

Our process for developing Colorado SHIFT included over one hundred stakeholders from more than fifty organizations, who dedicated time to attend meetings, brainstorm, share information on existing initiatives and other evidence, react to draft language, and review documents. At the conclusion of this process, participants agreed to continue to contribute through providing statewide technical assistance, refining the Colorado Health Care Innovation Plan, participating in Learning Collaboratives, and continuing to assist in outreach to colleagues and additional stakeholders. Letters of support have been included with our application from over forty stakeholder organizations and associations that have made a real and meaningful contribution and commitment to support Colorado's proposal and pledge to continue working toward successful implementation.

Our measurement strategy specifically mentions the risk inherent if stakeholders do not buy in to performance and accountability metrics to evaluation the initiative, and offers the mitigation strategy of using existing support for common measures already included in Meaningful Use and the CPC Initiative. Another risk related to stakeholder engagement relates to lack of participation and support for regional and state learning collaboratives. Consultation with

Colorado's established leaders in learning collaboratives, with a track record of providing meaningful and valuable information to providers will minimize this risk. Stakeholder engagement has been and will continue to be a critical part of developing, implementing and refining the health care system transformation strategy.

b. Required state legislative action

Colorado's legislature has already approved the legal infrastructure required for Colorado SHIFT to move forward, including support of the ACC, the All-Payer Claims Database (APCD), the Colorado Clean Claims Collaborative, and more recently, Medicaid payment reform. HB 12-1281 charged Colorado Medicaid with testing new payment approaches within the ACC in 2013-2014, including global payments, risk adjustment, risk sharing, and gainsharing, based on proposals from the ACC RCCOs and other partner organizations. The legislature has supported our goals in transforming the health care system and we expect continued support toward our shared vision of better care, better health, and lower costs.

12. Current clinical quality, beneficiary experience, and specific improvement targets

Colorado's Medicaid ACC has been rolled out to a subset of beneficiaries and providers, but most Medicaid services are still paid on an FFS basis. Medicaid patients who are not in any managed care may be served by 56 different provider types, which, for the most part, operate independently of one another. Each provider plays a valued role in treating or preventing illness and in maintaining or improving health, functional status and outcomes among clients; however, under the current system there is no consistent or uniform method to coordinate services across the health care delivery system. This lack of coordination frustrates providers as well as clients, and providers often have no way to know about treatment a client has sought elsewhere. For example, in the current system, if patient sees a primary care physician for routine or chronic

conditions, but visits a behavioral health provider for concerns about depression, and visits an emergency room for after-hours care, his providers are likely to remain unaware of each other and therefore be unable to offer coordinated, outcome-oriented follow-up care.

Colorado has begun implementing several initiatives to solve this lack of communication and care coordination. The ACC, on which Colorado SHIFT is based, was begun in May 2011 and is already showing promise as a model for improving care and containing costs. Similarly, Colorado's Multi-Payer PCMH pilot has seen good results, with some payer participants reporting substantial returns on investment in the program. The partnerships forged among payers and the lessons learned about payment mechanisms when there are multiple payers have been invaluable.

Colorado SHIFT will use a set of clinical quality and beneficiary experience outcomes that integrate measures from several current state and federal initiatives: CMS' Adult and Children Core Measure Sets, Meaningful Use Sets 1 and 2, Medicaid's ACC, CMS' CPC Initiative and Colorado's Ten Winnable Battles.²² If funded, Colorado SHIFT will work with stakeholders to develop and refine a set of core metrics that can be used across clinical environments statewide.

²² Additional information can be found in Strategy #5 of the Colorado Health Care Innovation Plan, starting on page 44.

<i>ACC Quality Metric</i>	<i>CPC Initiative Proposed Initiative Metrics</i>
<ul style="list-style-type: none"> • 30 day hospital readmissions • Emergency room visits, per thousand per year • High-cost imaging, per thousand per year 	<ul style="list-style-type: none"> • All-condition readmission • CAHPS: patient satisfaction • CAHPS: health status/functional status • Admissions for COPD • Influenza immunizations for patients >50 years old • Tobacco use assessment and intervention • Colorectal cancer screening • Breast cancer screening • Diabetes: Hemoglobin A1c poor control • Diabetes: blood pressure management • Diabetes: LDL management and control • Controlling high blood pressure • Ischemic Vascular Disease: complete lipid panel and LDL control • Beta blocker therapy for LVSD • Depression Screening and Follow-up Care

13. Current population health status by target population and the target outcomes expected from the model

Through Colorado SHIFT, we are targeting high-risk, high-cost patients with co-occurring chronic disease and behavioral health issues. Having a place where one can seek primary care is often referred to as a usual source of care. According to findings from the Colorado Household Access Survey, in 2011, approximately 12 percent of Coloradans reported not having a usual source of care.^{23,24}

Coloradans may choose to use an emergency department when they have a health problem. Emergency department use increased between 2008-2009 and 2011, regardless of whether an individual had a usual source of care. Nearly 80 percent of Coloradans who went to an emergency room for care in 2011 indicated they needed care after the normal operating hours of a doctor’s office or clinic. Behavioral health issues are a persistent concern for Colorado. Among Colorado’s adults ages 18 and older. Over 20 percent had a mental illness while 5.2

²³ Colorado Health Institute analysis of 2008-2009 Colorado Household Survey; Colorado Health Access Survey, 2011, Denver, CO: The Colorado Trust.

²⁴ Additional information can be found in Appendix A, Question 3, of the Colorado Health Care Innovation Plan, beginning on page A-6.

percent had a severe mental illness.²⁵ One-third of Coloradans, or 1.5 million, are in need of mental health or substance use disorder care. Nearly one in 12 Coloradans, or 450,000, have a severe need for these services.²⁶

These statistics illustrate the compelling need for Colorado SHIFT's integrated care model. By integrating primary care, behavioral health, and chronic disease prevention using a model that builds on our experiences, Colorado can increase the number of individuals with a usual source of care, better manage complex chronic conditions, and increase coordinated care, which in turn will reduce emergency department use and lead to lower costs.

14. Payment Models and State Plan Authorities Requiring Federal Authorization

Colorado does not need to exercise or request any waivers of Medicare or Medicaid to support and transform care delivery as proposed in this demonstration. The global payments that will be enabled for qualified practices in our model are defined as managed care under federal Medicaid regulations.

Any state considering expanding Medicaid managed care must weigh the potential benefits against the actual loss of significant Upper Payment Limit (UPL) funds that play an important role in state Medicaid programs, especially for Safety Net hospitals. Current UPL rules only allow services paid on a FFS basis to be counted towards calculating UPL payments. In many cases, the loss of UPL dollars would far outweigh any savings realized through the transition to the managed care system. States essentially have three options under the current UPL rules:

1. Maintain the existing FFS client base and continue to receive current UPL funding

²⁵ Substance Abuse and Mental Health Services Administration. (2012). *Mental Health, United States, 2010*. HHS Publication No. (SMA) 12-4681. Rockville, MD: Substance Abuse and Mental Health Services Administration.

²⁶ Status of Behavioral Health Care in Colorado: TriWest group. (2011). *The status of Behavioral Health Care in Colorado – 2011 Update*. Advancing Colorado's Mental Health Care: Caring for Colorado Foundation, The Colorado Health Foundation, The Colorado Trust, and The Denver Foundation: Denver, Co.

2. Transition to managed care and loss the ability to claim UPL funds
3. Seek a Federal demonstration waiver to find a mutually agreeable solution that preserves the existing UPL funds and allows for the expansion of Medicaid managed care.

The third option above is the only option with the potential to increase the quality of care, produce better outcomes, create savings for the Federal government and state governments, and maintain funding levels for safety net providers in order to preserve the state Medicaid programs. Examples of states that have tried to tackle this problem through demonstration waivers or other creative mechanisms include Florida, Texas, California, and Georgia. There are also examples of states that have had to make the hard decision to not only avoid expanding managed care, but have eliminated it all together, such as Illinois.

Although implementation of Colorado SHIFT is not dependent on CMS approval of a payment mechanism, we believe that a demonstration waiver will be necessary to ensure sustainability following the 36-month funding period, and we look forward to working with CMS to assess our options.

15. Describe any other targeted improvements not presented above

While Colorado SHIFT seeks to integrate behavioral health and primary care with multiple payers in the short term, this proposal sets the stage and provides lessons for future integration of public health, oral health, and long-term services and supports in the long term.

16. Project processes and operational planning

a. Data collection and reporting

Claims data will be utilized to analyze high cost and high utilization using data grouped by clinically meaningful categories. As clinical data sources become more standardized and interoperable, clinical data can be incorporated into such analyses and enrich practices' ability to

target interventions based on detailed health status. Ultimately, Colorado SHIFT infrastructure will provide the tools to analyze patient-specific clinical data to and track targeted interventions, and payment reform will be tied to practices' ability to collect data and show the impact of their integration efforts. Colorado SHIFT will employ a multi-level data collection and reporting strategy that encompasses claims and utilization data, clinical data, patient and provider experiences, and process measures. Key components include the APCD, hospital Admit-Discharge-Transfer (ADT) feeds, consensus metrics developed in partnership with stakeholders, EHR and registry tools, and the Colorado Information Marketplace, a platform for data exchange between state and state-authorized entities.

Colorado's APCD was created in 2010 with the passage of House Bill 10-1330. A statewide warehouse of claims data from Medicaid, Medicare and commercial payers, the APCD (coming online November 2012) will provide a comprehensive picture of health care spending and utilization in Colorado. Claims data from the APCD will facilitate analysis at both the community level as well as from a statewide perspective. Specific analyses that can be generated include total cost of care metrics, cross payer impact analyses, comparative analysis of payment model impact, and transitions of care, including patterns of care post hospital discharge for Medicare and Medicaid patients. In addition to providing claims data for analysis, designing interventions, and assessing gaps in care, participating IPCPs will have access to near-real-time feeds of HL-7standard ADT messages from all hospitals participating in the Colorado Regional Health Information Network (CORHIO) and Quality Health Network (QHN). Because these messages will be delivered in near-real time, they will be more immediately actionable than claims-based data.

The infrastructure for collecting and analyzing clinical data will rely upon registries, as created by or extracted from practices' EHRs. Since most EHRs collect and store data differently, particularly across medical and behavioral health products, it is important to start to strategically develop practices' capacity to collect data in a standardized way. In addition, as Colorado works toward more global models of funding, a level of standardization of clinical data is absolutely necessary to best assess cost, quality, and outcomes.

As part of an effort to improve comparability across data sets, the state will leverage the Colorado Information Marketplace and the ability to link data sets utilizing enterprise-wide identity management services. The Colorado Information Marketplace provides a platform for information exchange between state and state-authorized entities by 1) ensuring proper data governance (data use agreements, role-based access, data exposure limitation); 2) providing a "Link" solution for identity resolution and record matching; and 3) facilitating publication of data sets to be exchanged. The state will analyze how health-related data sets can be linked, combined, or compared through the Colorado Information Marketplace, including significant efforts to define necessary data governance controls (e.g., compliance with HIPAA, HITECH) and establish specific implementation plans for priority data sets.

IPCPs will be required to develop and report on their strategies for identifying and tracking those in their patient populations who are in most need of targeted interventions based on appropriate levels of care. Practices will be supported in this effort by the state's work to make claims and clinical data available to participating practices, but practices will also need to develop their own processes for augmenting and effectively utilizing this data to meet program participation requirements. Practices will provide to the state a detailed strategy to develop and

support processes for targeting interventions to specific patient populations and tracking and reporting on process and clinical outcomes as described below.

In addition to a cohesive data strategy approved by the applicable RCCO and Colorado SHIFT, IPCPs must be able to stratify and report on patients included from participating sites who meet clinical criteria defined by ICD-9 codes for specific behavioral health issues and chronic disease conditions. Extracting data from practices' EHRs will become a critical core component of payment reform and measuring the impact of the Colorado SHIFT.

b. Provider payment systems

Colorado SHIFT is managed by the Colorado Department of Health Care Policy and Financing (HCPF), which has strong staff and vendor expertise to support risk acuity adjustments and outcome based purchasing models.

c. Model enrollment or assignment processes

Attribution – the process by which patients are enrolled and assigned to providers – is a core competency for Colorado. Since inception of the ACC, Colorado assigned a dedicated team of analysts to work in cooperation with the SDAC to optimize the attribution methodology for Medicaid. HCPF continues its work to build trust in its attribution methodology, often travelling to meet with providers and patient advocates across the state to review the methodology and discuss potential pros and cons of proposed changes.

Model enrollment for Colorado SHIFT should be viewed through two lenses. First, by looking at patients receiving care in ACC and CPC Initiative-affiliated primary care medical homes. Currently, the ACC serves 140,000 Medicaid clients, with expansion plans in place to serve 200,000 by the beginning of 2013. Although there is no complete estimate for patients reached through CPC Initiative practices, CMS estimates the program will serve at least 41,000

Medicare beneficiaries. Nearly all of these providers also serve patients with private insurance who will benefit from the model's integration strategies. The second lens requires a recognition that the local flexibility component of our model prevents us from accurately determining how many patients will receive which kind of services at this point in time. Ultimately, through replication of the proposed model and statewide infrastructure supports, all individuals in a PCMH will have access to integrated services contemplated in Colorado's model.

d. Contracting and administrative processes

HCPF, the designated fiscal agent and primary implementation partner for this project, follows Colorado's state procurement code for state agencies when contracting, sub-granting, or otherwise disseminating funds to project partners. For funding to be used by the Governor's Office or another state agency, we may use an Interagency Agreement. For grant-specified contractors, we will follow our regular contract review and execution process, including HIPAA Business Associate Agreements where necessary, and we will require all contractors to follow the Federal Regulations required by this FOA and any Cooperative Agreement that results from Colorado's proposal. For funding that does not have a grant-specified recipient, and that is over the Purchase Order allowable amount, we will follow our standard competitive bid process.

To ensure that the grants we intend to make are fair and competitive, we will release a request for proposals as soon as possible after the Cooperative Agreement is signed. We expect applications from private entities, as well as from among the seven RCCOs already contracting with HCPF. The RFP process, with procurement code-specified posting, response and contesting deadlines, can take up to six months, but assures openness, fairness and competition in the distribution of funds. We will also follow State Personnel rules and our standard agency Human Resources process in the posting and hiring of positions funded under the Cooperative

Agreement. We recently completed a LEAN-Six Sigma time-to-hire process, as well as implemented a new on-boarding process for new hires. Together, these will help put project staff in place within six months of signing the Cooperative Agreement.

e. Continuous improvement analysis and performance optimization process

An additional dedicated LEAN-Six Sigma staff member will be hired for Colorado SHIFT. We will provide green- or black-belt level training, which will provide deep enough expertise to serve as a resource for project grantees needing business process assistance. Staff trained in LEAN through this funding will use LEAN processes with external stakeholders, such as RCCOs, BHOs, health plans, and providers, to eliminate redundancies and align service coordination and interventions. Skills learned in this training will be incorporated into existing policies and procedures, and the two LEAN staff within HCPF will serve as a resource to others in order to sustain what is learned and put into practice. LEAN staff will work internally to support cross-functional teams and help streamline administrative processes, both of which will help Colorado SHIFT meet timeline targets.

f. Project management, governance structure, and Colorado SHIFT staffing

The Governor's Office will work closely with HCPF, Colorado's Medicaid State Agency. Susan Birch, MBA, BSN, RN was appointed the Executive Director of HCPF by Governor Hickenlooper in January 2011. As a member of the Governor's cabinet, Ms. Birch directs the Department's efforts to improve the health of Medicaid and CHP+ clients, increase access to care and contain costs. Sue was previously the Chief Executive Officer of Northwest Colorado Visiting Nurse Association in Steamboat Springs, Colorado. She was instrumental in expanding programs, developing strategic partnerships and strengthening operations. The agency moved into a nurse- led model of integrated community health services including primary care, home

and hospice care, public health and aging services. She strongly supports health care integration and payment reform.

Suzanne Brennan, Medicaid Director at HCPF, provides oversight for all Medicaid program divisions and activities. Prior to her work at HCPF, Ms. Brennan was a Senior Project Officer at the Colorado Health Foundation and responsible for funding many organizations integrating care. Ms. Brennan has valuable experience in aligning project aims and coordinating funding for separate but related projects.

HCPF leadership will work with the staff members involved in crafting Colorado SHIFT, who each possess significant knowledge of policy, processes, and innovation. Lorez Meinhold, former Senior Policy Director in the Governor's Office of Policy and Research, has recently been appointed as the Community Partnerships Office Director and Deputy Executive Director at HCPF. Ms. Meinhold will focus on building and managing Community Partnerships and relationships that integrate HCPF strategy and activities with statewide and national health reform initiatives. Other key staff include Jed Ziegenhagen, Director, HCPF Rates and Analysis Division, Dr. Judy Zerzan, HCPF Chief Medical Officer, and countless staff in HCPF's Rates, Communication, Budget, Accounting, and Procurement sections or divisions.

Management of this project will be incorporated into HCPF's existing management process, with the Colorado SHIFT Project Manager functioning under the Medicaid Office at HCPF, and other SHIFT staff reporting to them, with the exception of financial personnel, who will report to their respective divisions. This includes weekly project status reporting and one-on-one meetings, as is common for all staff. Meetings will cover activities in process, as well as review of projects, will document upcoming tasks, and identify potential issues before they become concerns. There will also be regular meetings with Governor's Policy staff to ensure

consistency of goals and messaging, and to maintain clear statewide focus and communication with all SHIFT partners, contractors and stakeholders.

The groundwork for this proposal is already laid since it builds upon implementation of the ACC Program. HCPF has inventoried its current capacity and infrastructure and compared that to anticipated needs during both the development phase and the implementation phase. This proposal includes funding for nine positions. These personnel are needed to develop implement and oversee the infrastructure changes and contractual responsibilities needed to further the shift to integrated health care with a multi-payer mix in Colorado. Colorado has several staff identified as key to the success of this contract as illustrated in the following table:

Position	Responsibilities
<i>Colorado SHIFT Project Manager</i>	Responsible for managing SIM activities, including: <ul style="list-style-type: none"> ▪ Executing and overseeing contracts ▪ Coordinating payment reform initiatives ▪ Ensuring compliant reporting of project operations ▪ Facilitating completion of government monitoring plans ▪ Providing information to evaluate project results
<i>SHIFT LEAN Instructor</i>	Responsible for coordination and execution of the LEAN process within Colorado SHIFT
<i>SHIFT Contract Manager</i>	Responsible for oversight of innovation projects and funding, ensuring that integration proposals align with SHIFT objectives, and targets are reached.
<i>SHIFT Collaboration Coordinator</i>	Responsible for oversight of the Learning Collaborative initiatives.
<i>SHIFT Program Assistant</i>	This position would be responsible for assisting the SIM Project Manager and other SIM funded staff in organization. This would involve tasks such as scheduling meetings, printing documents for meetings, assisting in report writing or other grant related tasks.
<i>Sustainability Coordinator</i>	Responsible for ensuring sustainability of payment and delivery models and coordinating with federal government to seek authorization for on-going payment structures.
<i>SHIFT Payment Reform Coordinator</i>	Responsible for the coordination of payment reform initiatives included in the project, and will recommend efficiencies in payment reform implementation.
<i>SHIFT Project Accountant</i>	Responsible for ensuring that payment to PCMPs and contractors is accurate and complete, including shared savings, bundled payments, etc.

C. Expected Transformation of Major Provider Entities and Evidence of Commitment

Practice transformation is central to Colorado’s proposed model, and is discussed throughout this proposal. Building upon existing innovations at the payer and provider level

across the state, our model seeks to advance behavioral health outcomes by integrating behavioral health into primary care practices. Although our model describes practice- and region-level interventions at length, our aim is to assess where a provider is currently with regard to integration, meet the provider at that level, and move them along the continuum of integrated, person-centered care. Enhanced integration and care coordination, particularly for high-utilizers, will reduce per capita expenditures, increase patient satisfaction, and improve outcomes. Prevention-oriented behavioral health screenings will help to bend the cost curve in the long term.

Many providers are prepared for and willing to advance this type of integration, as evidenced by the 73 practices participating in CPC Initiative, the 50 providers engaged in the Beacon Consortium, and over 250 practices that have engaged in practice readiness efforts using the services of HealthTeamWorks, a nonprofit coaching organization. Additionally, the regional-local partnership between providers and RCCOs at the heart of the ACC provides the basic infrastructure to facilitate practice transformation statewide. Similarly, Colorado's major hospitals and hospital systems are engaged in these efforts, either as affiliates of provider networks or as independent parts of the healthcare delivery system.

Denver Health's selection as an Innovation Challenge site is the ideal example of a hospital leading statewide innovation in integrated care. Private payers are also engaged in incentivizing practice transformation and integration. Our letters of support from provider and payer entities provide strong evidence that the provider community in Colorado is supportive of this initiative.

D. Roles of other payers and stakeholders

Industry leaders across health systems are recognizing the role of integrated primary and behavioral health care services in clinical improvement, cost effectiveness, and patient satisfaction. As private healthcare systems embraces integration, Colorado aims to make integration viable in all systems of care by providing relevant, timely information, and resources related to private financing of integrated care.

Colorado's commercial health plans have shown their commitment to person-centered, integrated, accountable care through participation in the Multi-Payer PCMH Project and the CPC Initiative. This model combines Medicare, Medicaid, and seven commercial payers and thus presents an ideal opportunity to apply our integrated care approach in the commercial market. The CPC Initiative uses payment reforms to facilitate the provision of coordinated care. The 73 primary care practices chosen to participate in CPC Initiative represent the "tip of the spear" for testing new coordinated care approaches because they are some of the most advanced in the state. These practices will be using their PMPM payments to support comprehensive primary care functions, all of which support the movement toward integrated care.

To an even greater extent than the other CMMI-funded initiatives described in this proposal, CPC Initiative payers and practices will be integral participants in the proposed Colorado SHIFT learning collaboratives as they broaden their scope.

E. How Model Links to the Colorado Health Care Innovation Plan

Our proposed model is a key component of the Colorado Health Care Innovation Plan. We have provided references throughout the narrative to provide connections to plan strategies. Ultimately our vision for health system transformation as outlined in the Plan is broader than our model testing proposal. However, this proposed integration is a starting point for our vision. Additional information on regulatory changes and connections to public health are articulated in the Colorado Health Care Innovation Plan.

F. Multi-Stakeholder Commitment

Colorado is committed to working with a broad range of stakeholders throughout the implementation process through a number of strategies. The state will contract with a neutral convener to implement and report upon the stakeholder engagement process.

Stakeholders working to develop Colorado SHIFT to-date have included: academic leaders; advocates; foundations; nonprofit health policy entities; health data experts; Innovation Challenge Grantees; public and private payers; legislators, regulators, the Governor's Office, and six departments within Colorado state government; provider representatives; public health representatives from state and local levels; and regionally-based Behavioral Health Organizations and Regional Care Collaborative Organizations.

As implementation progresses, it will be crucial to maintain engagement with these groups and expand our engagement efforts to include more health care consumers and community-level representatives, a broader swath of provider groups, and others to ensure the feedback we receive is truly representative of the Colorado community. Our existing stakeholders support this effort and have committed to ongoing participation.

The primary goals for our stakeholder engagement strategies are to develop buy-in beyond those who actively participated in the model development process and educate and engage stakeholders in Colorado SHIFT efforts at the local, state, and regional levels. We will create opportunities for meaningful stakeholder participation throughout the grant period, and leverage existing advisory committees, task forces, and workgroups in the public and private sectors with a broad range of representatives to reduce duplicative conversations. We will solicit feedback periodically and use it to refine the model, and learn from experiences and shared best

practices to identify potential for replication. Our specific strategies to achieve these goals are divided into three phases, as follows:

a. Phase 1: Pre-Launch

We plan to solicit assistance from existing stakeholders, as well as advocacy and affiliate groups, to share information and reach a broad audience of individuals and organizations that may have an interest in Colorado SHIFT. In addition to those listed above as current stakeholders, we will reach out to consumer and patient advocates, especially those who represent individuals with chronic conditions, persistent mental illness, and substance abuse. We will also share solicit assistance and share information with employer purchasers.

As implementation planning gets underway, we will engage stakeholders to identify a complete list of complementary advisory groups, task forces, and workgroups already operating that could serve as formal work partners of Colorado SHIFT. The following represents a sample of potential partners to achieve broad stakeholder engagement that currently serve as a valuable source of subject-matter experts and organizations actively involved in health systems planning:

Potential Partner Stakeholder Groups for Colorado SHIFT	
<i>Facilitated by State Agencies</i>	<i>Facilitated by Nonprofit Organizations</i>
ACC Program Improvement Advisory Group	CIVHC Payment Reform Workgroup
Behavioral Health Transformation Council	CIVHC Data & Transparency Advisory Group
	CORHIO HIT Stakeholder Group

In addition, we will convene stakeholders to discuss the structure for ongoing engagement throughout the funding period. Within 3-6 months of receiving funds, this convened group will determine if Colorado SHIFT requires an independent advisory committee through the grant period, or if it can be incorporated into an existing group and complemented my activities of the Colorado SHIFT learning collaborative.

Finally, we will create an interagency workgroup comprising key state personnel related to Colorado SHIFT activities for the duration of the grant, and develop a Colorado SHIFT website and communication plan to share information and conduct periodic stakeholder surveys.

b. Phase 2: Implementation

The learning collaborative, discussed elsewhere in the draft, is the key mechanism through which communication with partners engaged in Colorado SHIFT activities will occur. In addition, we will establish a feedback loop among stakeholder groups, project workgroups, project staff leads, and the learning collaborative so that input is continually synthesized and shared, and to create opportunities for improvement.

We will also create links between the Colorado SHIFT learning collaborative and key patient advocate groups statewide to conduct focus groups centering on patient experiences that can be shared with project leaders, policymakers, and providers. We will ensure that large convenings and symposia facilitated through the learning collaborative are forums for broad stakeholder participation from the public, private, and nonprofit sector, and ensure these meetings are accessible for remote participation via the internet to stakeholders who are in remote areas, have limited mobility, or are otherwise unable to attend in person.

c. Phase 3: Completion

Near the end of the funding period, it will be important to assess our progress based largely on what we have set out to achieve. We will convene stakeholders who participated throughout the planning and implementation phases regarding the overall grant experience, share data collected to measure progress, and solicit recommendations for ongoing work. Finally, we will synthesize the grant experience, key findings, and plans for future work into a final report made available to the community and distributed to broad stakeholder groups.