A Comprehensive Look at Colorado's Transformation Efforts

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Multi-Payer Collaborative Background

Multi-payer **network** of public & private health care payers focused on strengthening primary care

Convened as part of Comprehensive Primary Care Initiative

Evolving to support SIM

- Aetna
- Anthem
- Cigna
- Colorado Access
- Colorado Choice
- Health Care Policy & Financing
- Humana
- Kaiser Permanente
- Rocky Mountain Health Plans
- Medicare
- UnitedHealth Group

Participate in CPC, SIM & data aggregation | Participate in CPC & SIM only | Participate in SIM only | Participate in CPC & data aggregation | Participate in CPC only

Shared Mission

A shared commitment to increased quality, improved efficiency, higher value, and continuous improvement and diffusion of innovative and successful strategies through increased system accountability, improved health outcomes and experiences for patients and providers, and decreased total cost of care.

CPC Colorado overview

Highly Competitive market

- No single payer has a large market share
- Market Consolidations in providers, systems and payers

No single strategy fits needs of market diversity

- Diverse demographics and services locations
- Provider structures
- Availability of services

Strong Foundation of Practice Transformation pre-dating CPC

Local Expertise, National Prominence

4 years

8 payers

72 practices

497 providers

443,718 patients

Key accomplishments

Created framework for monthly meetings

Data Aggregation Vendor
- Developed and submitted RFP for Data Aggregator
- Vetted and identified finalist
- Worked with Rise Health to negotiate 8 individual payer contracts
- Successfully submitted data
- Go Live 6/1/15!

Shared CPC Practice Site Visits to drive data aggregation use

Laid foundations for SIM Multi-Payer initiative

“Secret sauce”

Mixture of expertise in Multi-Payer Collaborative Participants

- Contracting, Medical Directors, Transformation, Policy

Strong facilitation – Oregon State University, Center for Evidence-Based Policy

- Expertise and Support in navigating difficult topics
- Synthesized discussions and ideas to reflect all participants
- Clarified actions to move forward
- Moved beyond program updates to creating a shared vision

Shared Problem to Solve Broke Down Barriers ~ Shared Success when it worked!

Commitment to seeing this work succeed

Colorado SIM

VATSALA PATHY

DIRECTOR, COLORADO STATE INNOVATION MODEL

OFFICE OF THE GOVERNOR

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.

Colorado SIM

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.

SIM Triple Aim

Improved Population Health

Improvements in 12 physical and behavioral health outcomes

Better Experience of Care

Access to integrated behavioral and physical healthcare for 80% of Coloradans by 2019

Lower Costs

$126.6 million in cost of care savings by 2019; $85 million in annual savings thereafter

SIM Approach

80% of Coloradans have access to integrated care

Payment Reform

Development and implementation of value-based payment models that incentive integration and improve quality of care.

Practice Transformation

Support for practices as they accept new payment models and integrate behavioral and physical health care.

Population Health

Engaging communities in prevention, education, and improving access to integrated care.

HIT

Secure and efficient use of technology across health and non-health sectors in order to advance integration and improving health.

Collective Impact

The Colorado SIM Initiative serves as a central hub for all major healthcare actors in Colorado, helping to identify common priorities, coordinate efforts, eliminate duplication, and gather best practices.

Building on Prior Success

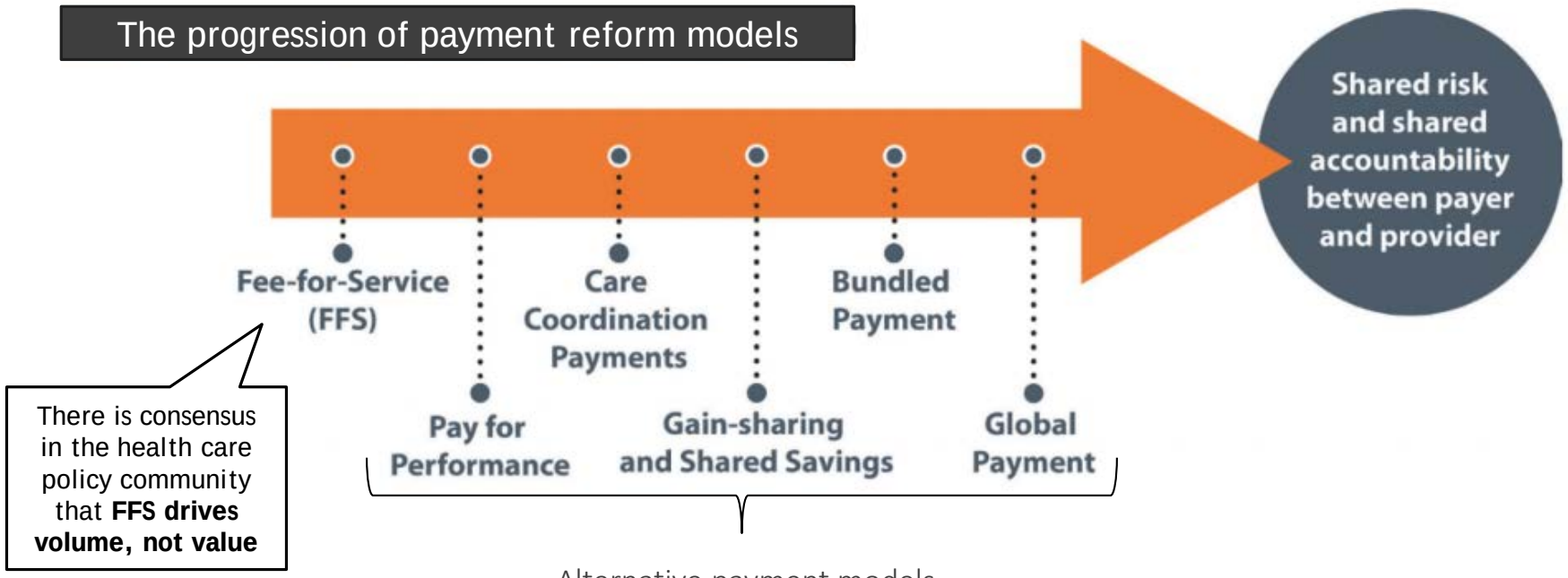
SIM builds on success of the Comprehensive Primary Care Initiative (CPCi), the Accountable Care Collaborative (ACC), and multiple efforts by private payers.

Leverages Colorado Multi-Payer Collaborative payers convened in 2012 to support CPCi. Focuses on organizational alignment and consistency across payers.

SIM has also convened its own Payment Reform workgroup and has received firm commitments from several payers to pilot alternative payment models. More commitments expected soon.

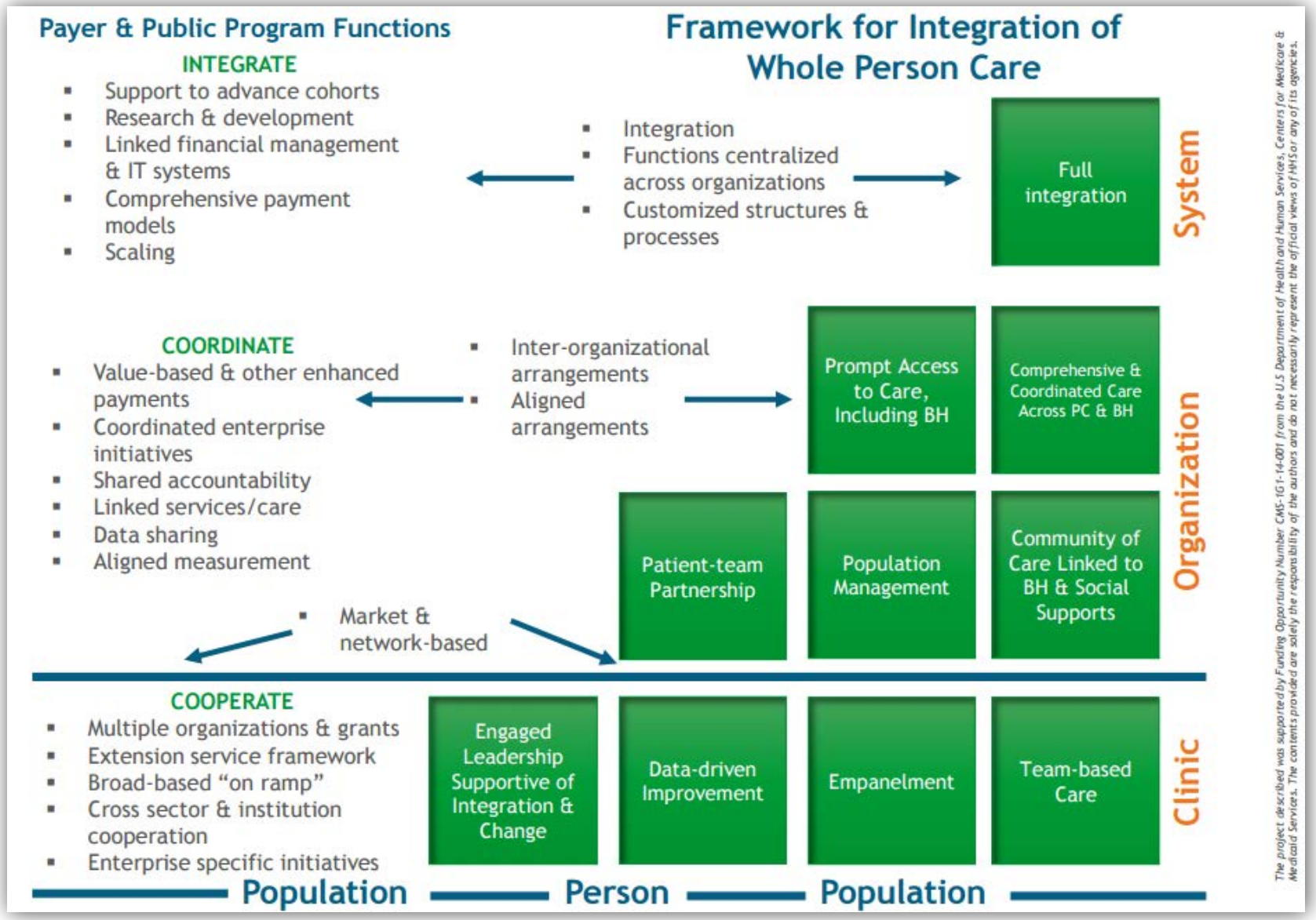
Value-Based Payment Reform

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$



Source: "New Approaches to Paying for Health Care: Implications for Quality Improvement and Cost Containment in Colorado," July 2012, CIVHC and CHI; "Measuring Success in Health Care Value-Based Purchasing Programs," 2014, RAND Corporation

SIM Conceptual Framework



Adapted from 'The 10 Building Blocks of High-Performing Primary Care," Bodenheimer, Thomas. Ann Fam Med March/April 2014 vol. 12 no. 2 166-171

Clinical Quality Measures

18 clinical quality measures, used to gauge quality of care at SIM-participating practices.

Collected from reports at the practice level and from claims data.

Determined by subject-matter experts on the SIM Steering Committee. Approved by Colorado Multi-payer Collaborative and SIM Payers Workgroup.

Clinical Quality Measures

Measure Condition	Citation	Data Source
Breast Cancer Screening	NQF 0031	Claims
Colorectal Screening	NQF 0034	Claims
Depression Screening	NQF 0418 (Adol/Adult) or NQF 1401 (Maternal)	Practice
Substance Use Disorder (SUD) Screening	NQF Composite 2597	Practice
Flu	NQF 0041	Practice
Asthma	NQF0036	Practice
Obesity	NQF 0421 (Adult) or NQF 0024 (Child/Adol)	Practice
Depression Screening	NQF 0418	Practice
Maternal Depression	NQF 01401	Practice
Developmental Screening	NQF 1448	Practice

Measure Condition	Citation	Data Source
Anxiety	GAD-7	Practice
Hypertension	NQF 0018	Partial claims & practice
Tobacco	NQF 0028	Practice
Diabetes: Comprehensive care	NQF 0059	Practice
Diabetes: Blood pressure management	NQF 0061	Practice
Diabetes: LDL management &	NQF 0064	Practice
Safety	NQG 0101	Practice
IVD	NQF 0075	Practice

Family/ Adult All Pediatric Optional

Family/Adult must report at least 1 optional measure

SIM HIT Strategy

Quality Measurement Tool

1. Addresses data quality
2. 18 Clinical Quality Measurements, (eCQMs) appropriate to a practice
3. Key to practice transformation
4. Extracts and Reporting

Data Acquisition and Aggregation

1. Clinical and Behavioral health data
2. Focus on clinical data in support of Clinical Quality Measurement data elements / value sets
3. Scalable for future use

Analytical Reporting

1. Addresses data quality
2. Reporting for multiple users, including cohort practices
3. National standards

Data Integration

1. Integrate clinical, behavioral health and claims data
2. Ability to analyze and report quality measurements and cost measurements
3. Assessment of the completeness of integration efforts

Telehealth 1) Expand broadband, state-wide, 2) Technology that facilitates sharing CCDs using nationally recognized interoperability standards, 3) Create Telehealth Resource Centers to engage providers and patients

Population Health

Provider Education: Web-based provider training on Pregnancy-Related Depression, Depression in Men, and Obesity & Depression.

Support for Community Collaboratives: 4-5 grants to community collaborative organizations working to implement evidence-based behavioral health prevention strategies.

Outreach and Education: Support for Local Public Health Agencies to implement strategies that engage communities on promoting awareness and reducing stigma around behavioral health.

Population Health Plan: Creation of a statewide Population Health Plan that outlines how SIM initiatives will improve the health of Coloradans.

Data Aggregation

SIM working to develop data sharing tool provided to participating practices with the aim of improving delivery of care and lowering costs.

Creates a “one stop shop” for practices to access patient data, instead of going to multiple payer websites.

Includes intuitive and user-friendly interface with powerful analytics.

SIM Office currently considering how to build upon success of RiseHealth’s *Stratus* ™ tool, used by Multi-Payer Collaborative.

Next Steps

MOU between SIM Office and participating payers anticipated in December with shared quality metrics.

Discussions regarding data aggregation and cost and utilization metrics.

Ongoing participation in Multi-Payer Collaborative.

Multi-Payer Data Aggregation

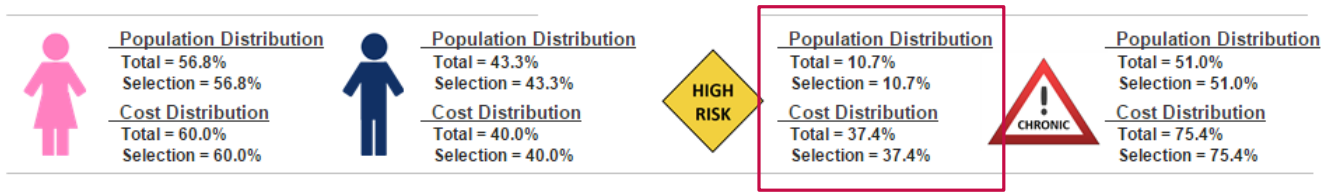
JEAN HAYNES

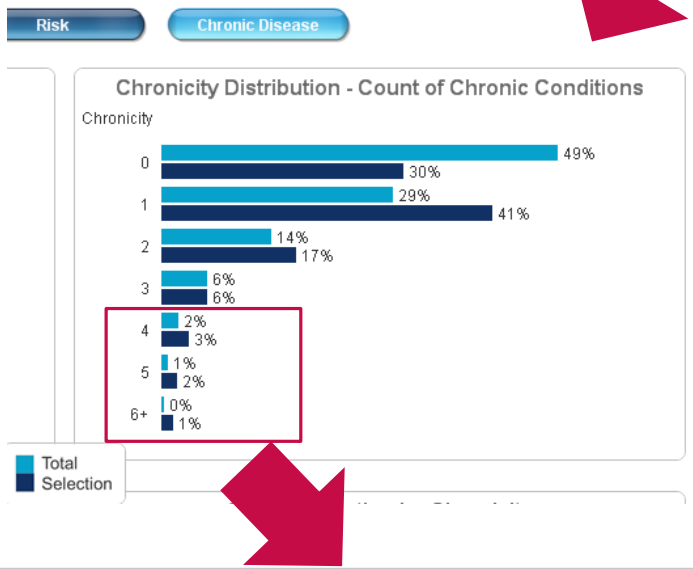
CHIEF POPULATION HEALTH OFFICER

UNIVERSITY OF COLORADO HEALTH

Example #1 - Risk Score Drill-Down

Step-by-Step
1. Select “Pop Metrics” Tab
2. Select High Risk
3. Select Patients with 3+ Chronic Conditions
4. Export patient detail
5. Provide Care Managers with patient lists



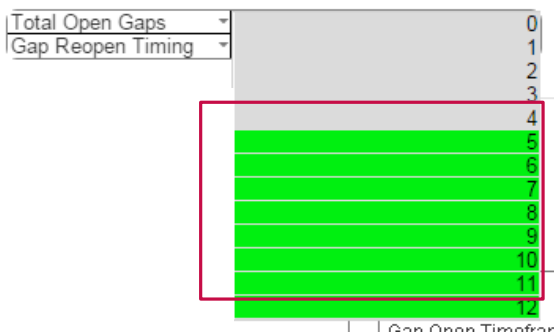


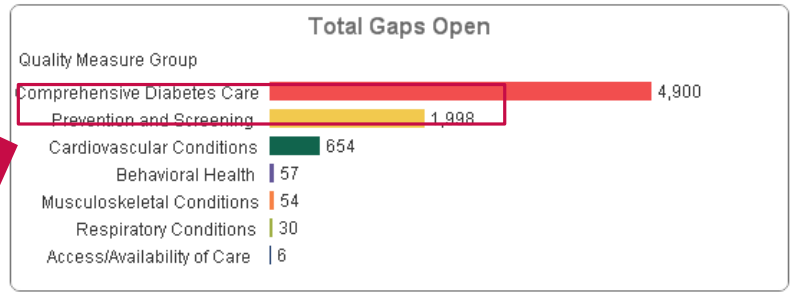
Patient Registry (n=220)

MPI	Patient Name	PCP	)PD	Diabetes	Depression	ER Visits	IP Admits	Readmitted 30 Days	Readmitted 90 Days	Allowed Amount
			69	115	107	159	195	32	59	$13,598,800.57
21596841	Patient_21596841	Provider_273637	1	0	0	0	0	0	0	$159,175.71
21663041	Patient_21663041	Provider_274848	0	0	1	0	2	1	1	$50,282.77
21688686	Patient_21688686	Provider_275264	0	1	0	0	0	0	0	$20,928.27
21604496	Patient_21604496	Provider_276930	1	0	0	0	1	0	0	$42,587.25
21544606	Patient_21544606	Provider_277298	1	0	0	0	0	0	0	$70,607.77
21605464	Patient_21605464	Provider_278570	0	0	0	1	1	0	0	$75,917.35
21571086	Patient_21571086	Provider_282138	0	0	0	1	0	0	0	$41,137.49
21691237	Patient_21691237	Provider_283335	1	1	1	0	1	0	0	$38,981.42
21600008	Patient_21600008	Provider_285221	0	1	0	1	0	0	0	$14,239.23
21713110	Patient_21713110	Provider_286652	0	0	0	3	0	0	0	$56,556.16

Example #2 - Care Gaps

Step-by-Step
1. Select “Care Gaps” Tab
2. Select Patients with 5+ Care Gaps
3. Select Prevention and Screening Gaps
4. Export patient detail
5. Provide Care Managers with patient lists





Gap Status Member Detail

Pt Name	Sex	Measure Type	Measure Name	Gap Status	Gap Closed Date	Gap (Re)Open Date	Days to Reopen
Patient_21530692	F	Prevention and Screening	Adult BMI Assessment (ABA)	0	-	8/31/2014	0
Patient_21530692	F	Prevention and Screening	Breast Cancer Screening (BCS)	1	2/19/2014	5/19/2016	627
Patient_21530692	F	Prevention and Screening	Colorectal Cancer Screening (COL)	0	-	8/31/2014	0
Patient_21530703	F	Prevention and Screening	Adult BMI Assessment (ABA)	1	9/7/2012	9/7/2014	7
Patient_21530703	F	Prevention and Screening	Breast Cancer Screening (BCS)	1	6/26/2014	9/26/2016	757
Patient_21530703	F	Prevention and Screening	Cervical Cancer Screening (CCS)	1	5/24/2012	5/24/2015	266
Patient_21530703	F	Prevention and Screening	Colorectal Cancer Screening (COL)	1	6/20/2011	6/20/2012	0
Patient_21530828	M	Prevention and Screening	Adult BMI Assessment (ABA)	0	-	8/31/2014	0
Patient_21530828	M	Prevention and Screening	Colorectal Cancer Screening (COL)	0	-	8/31/2014	0
Patient_21530951	F	Prevention and Screening	Adult BMI Assessment (ABA)	1	8/9/2014	8/9/2016	709
Patient_21530951	F	Prevention and Screening	Breast Cancer Screening (BCS)	1	11/13/2013	2/13/2016	531
Patient_21530951	F	Prevention and Screening	Cervical Cancer Screening (CCS)	1	5/8/2014	5/8/2017	981
Patient_21530951	F	Prevention and Screening	Colorectal Cancer Screening (COL)	1	5/3/2013	5/3/2014	0
Patient_21531025	M	Prevention and Screening	Adult BMI Assessment (ABA)	0	-	8/31/2014	0
Patient_21531025	M	Prevention and Screening	Colorectal Cancer Screening (COL)	0	-	8/31/2014	0
Patient_21531393	M	Prevention and Screening	Adult BMI Assessment (ABA)	0	-	8/31/2014	0
Patient_21531393	M	Prevention and Screening	Colorectal Cancer Screening (COL)	1	12/7/2012	12/7/2013	0
Patient_21531455	M	Prevention and Screening	Adult BMI Assessment (ABA)	1	8/12/2014	8/12/2016	712

Example #3 - Utilization

Step-by-Step
1. Select “Prov Compare” Tab
2. Selections of 0 PCP visits & Multiple ED visits
3. Identify Patient in Registry
4. Select Patient Detail for Claims level data

Last PCP Visit	Last ER Visit	Last Admit Date
5/9/2013	7/23/2014	8/6/2014

Name: Patient_21627375 Gender: F DOB: Age: 17 Phone: Provider PCP: Provider_369998

Address: City: State: Zip: E-Mail:

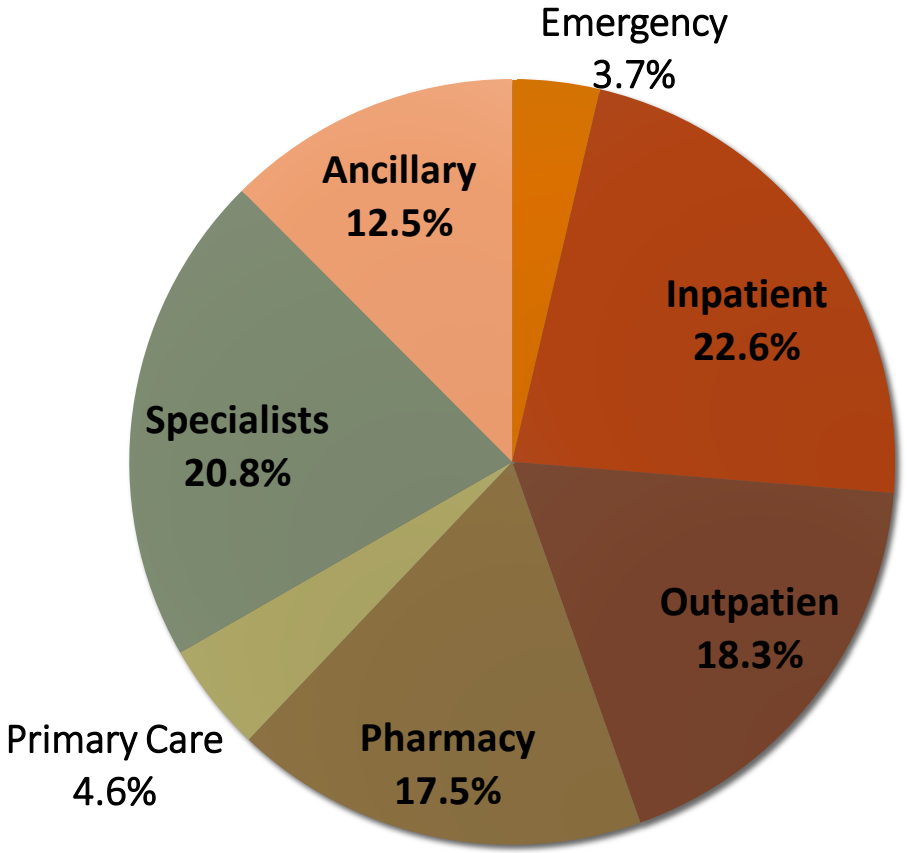
Date	Provider	Service Category	Primary Diagnosis	Total Allowed
2014-08-22	Provider_335180	Pharmacy	-	$21.15
2014-08-15	Provider_335180	Pharmacy	-	$21.15
2014-08-14	Provider_467077	Office Visit - Specialist	HEADACHE	$94.46
2014-08-12	Provider_335180	Pharmacy	-	$14.70
2014-08-07	Provider_404127	Radiology Professional	BENIGN INTRACRANIAL HYPERTENSION	$78.25
2014-08-06	Provider_330599	Anesthesia	BENIGN INTRACRANIAL HYPERTENSION	$1,295.04
2014-08-06	Provider_399098	Inpatient	BENIGN INTRACRANIAL HYPERTENSION	$7,580.00
2014-08-06	Provider_475527	Surgery	COMPRESSION OF VEIN	$1,260.15
2014-07-29	Provider_335180	Pharmacy	-	$7.74
2014-07-25	Provider_406269	Radiology Professional	BENIGN INTRACRANIAL HYPERTENSION	$165.34
2014-07-25	Provider_454464	Radiology Facility	BENIGN INTRACRANIAL HYPERTENSION	$2,569.80
2014-07-25	Provider_475527	Office Visit - Specialist	BENIGN INTRACRANIAL HYPERTENSION	$0.00
2014-07-23	Provider_380573	ER	BENIGN INTRACRANIAL HYPERTENSION	$2,175.87
2014-07-23	Provider_393905	Surgery	BENIGN INTRACRANIAL HYPERTENSION	$242.00
2014-07-23	Provider_512149	Emergency Room/Critical C...	BENIGN INTRACRANIAL HYPERTENSION	$205.90
2014-07-14	Provider_467077	Office Visit - Specialist	BENIGN INTRACRANIAL HYPERTENSION	$94.46
2014-07-12	Provider_380573	ER	BENIGN INTRACRANIAL HYPERTENSION	$3,037.96
2014-07-12	Provider_430563	Emergency Room/Critical C...	MIGRAINE UNSP W/O INTRACT W/O SM	$338.60
2014-06-29	Provider_380573	ER	HEADACHE	$1,869.65
2014-06-29	Provider_430563	Emergency Room/Critical C...	UNSPECIFIED ESSENTIAL HYPERTENSION	$307.34
2014-06-21	Provider_270811	Emergency Room/Critical C...	HEADACHE	$399.01
2014-06-20	Provider_380573	ER	HEADACHE	$1,935.97
2014-06-16	Provider_467077	Office Visit - Specialist	HEADACHE	$94.46
2014-06-12	Provider_335180	Pharmacy	-	$8.76
2014-06-11	Provider_454464	Outpatient Surgery	BENIGN INTRACRANIAL HYPERTENSION	$5,525.18
2014-06-11	Provider_475527	Surgery	COMPRESSION OF VEIN	$1,134.20
2014-06-04	Provider_300276	Ophthalmology	UNSPECIFIED PAPILLEDEMA	$48.75
2014-06-03	Provider_335180	Pharmacy	-	$26.54
2014-06-03	Provider_467077	Office Visit - Specialist	HEADACHE	$94.46
2014-05-29	Provider_369998	Office Visit - Specialist	HEADACHE	$94.46
2014-05-28	Provider_286292	Inpatient Visits	BENIGN INTRACRANIAL HYPERTENSION	$196.63

The Provider Experience

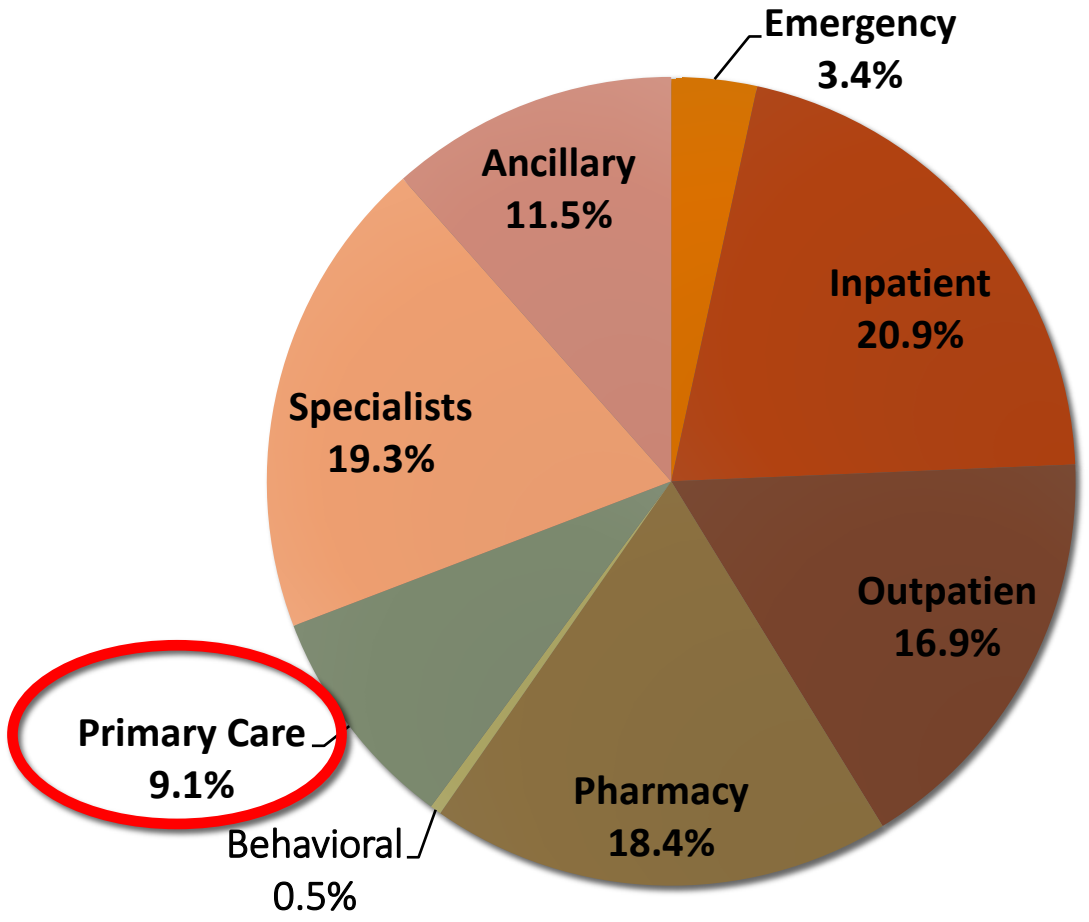
MICHAEL PRAMENKO, M.D.

PRIMARY CARE PARTNERS

Spending Pattern – Conventional FFS



Spending Pattern – Value Based



Isn’t the second pie bigger? No.

	Total Cost PMPM
Advanced Practices	$479.30
Behavioral Health Payments	$4.35
Total	$482.85
Conventional Network Average	$505.83
Risk Normalized Difference	-4.54%

The SHAPE Pilot

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PATRICK GORDON, M.P.A.

ASSOCIATE VICE PRESIDENT

ROCKY MOUNTAIN HEALTH PLANS

The take away

We can do a better job taking care of people by giving them seamless access to behavioral health in primary care

This means if a patient walks into primary care, there is a team there including behavioral health that can help with mental health, substance abuse conditions, and health behaviors

Behavioral health is a natural extension of the primary care function

This integrated approach can improve outcomes

This integrated approach can save money

People like it

Peek, C. J., National Integration Academy Council. (2013). Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. In Agency for Healthcare Research and Quality (Ed.), *AHRQ Publication No.13-IP001-EF*.

A Case for Integrating **Behavioral Health and Primary Care**

EUGENE S. FARLEY, JR. HEALTH POLICY CENTER
A Collaboration For Studies In Primary Care

66% **of primary care providers report** they are unable to connect patients with outpatient behavioral health providers **due to a shortage of mental health providers and health insurance barriers**[1]

20% of primary care office visits are mental health related[2]

46% **of adults will experience mental health illness or a substance** abuse disorder at some point in their lifetime[3]

67% of adults with a behavioral health disorder do not get behavioral health treatment[4]

[1] Cunningham PJ. Beyond parity: primary care physicians' perspectives on access to mental health care. Health affairs (Project Hope). 2009;28(3):w490-501.
[2] Center for Disease Control and Prevention. Percentage of Mental Health-Related Primary Care Office Visits, by Age Group - National Ambulatory Medical Care Survey, United States, 2010. Morbidity and Mortality Weekly Report. 2014;63(47);1118.
[3] Kessler RC, Wang PS. The descriptive epidemiology of commonly occurring mental disorders in the United States. Annual review of public health. 2008;29:115-29.
[4] Kessler RC, Demler O, Frank RG, Olfson M, Pincus HA, Walters EE, et al. Prevalence and treatment of mental disorders, 1990 to 2003. The New England journal of medicine. 2005;352(24):2515-23.

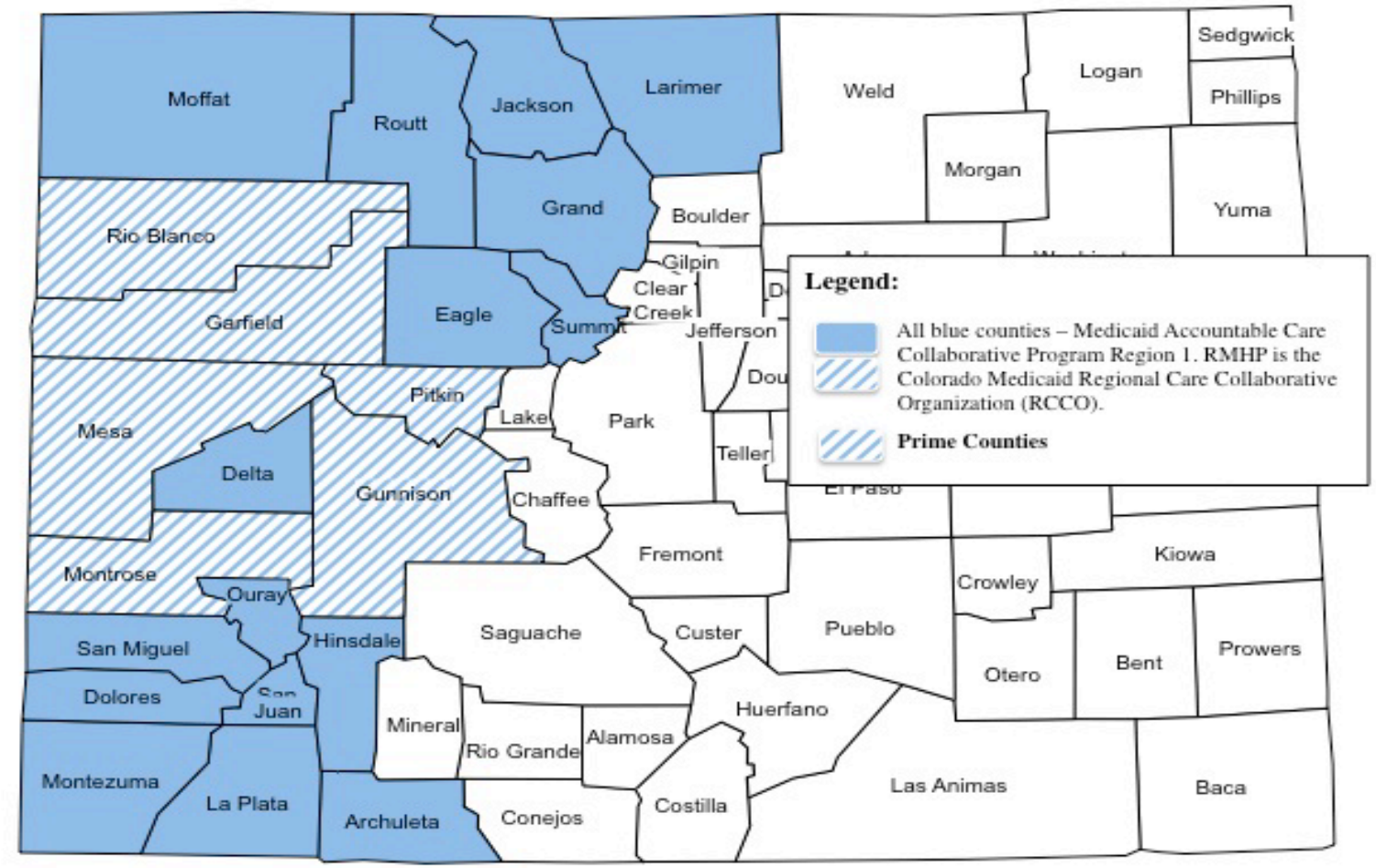
Change the payment, change the care

POLICY AND FINANCING RECOMMENDATIONS

SHAPE
Sustaining Integrated Care

- Three Year Project with CFHA, DFM, and RMHP
- Project launched in July 2012
- Year 1: Identified 3 control and 3 intervention practices
- 18 Month Study Period (Mixed method evaluation)
- 6 Months – Wrap-Up and Conclusions

Who/Where Is Rocky Mountain Health Plans?

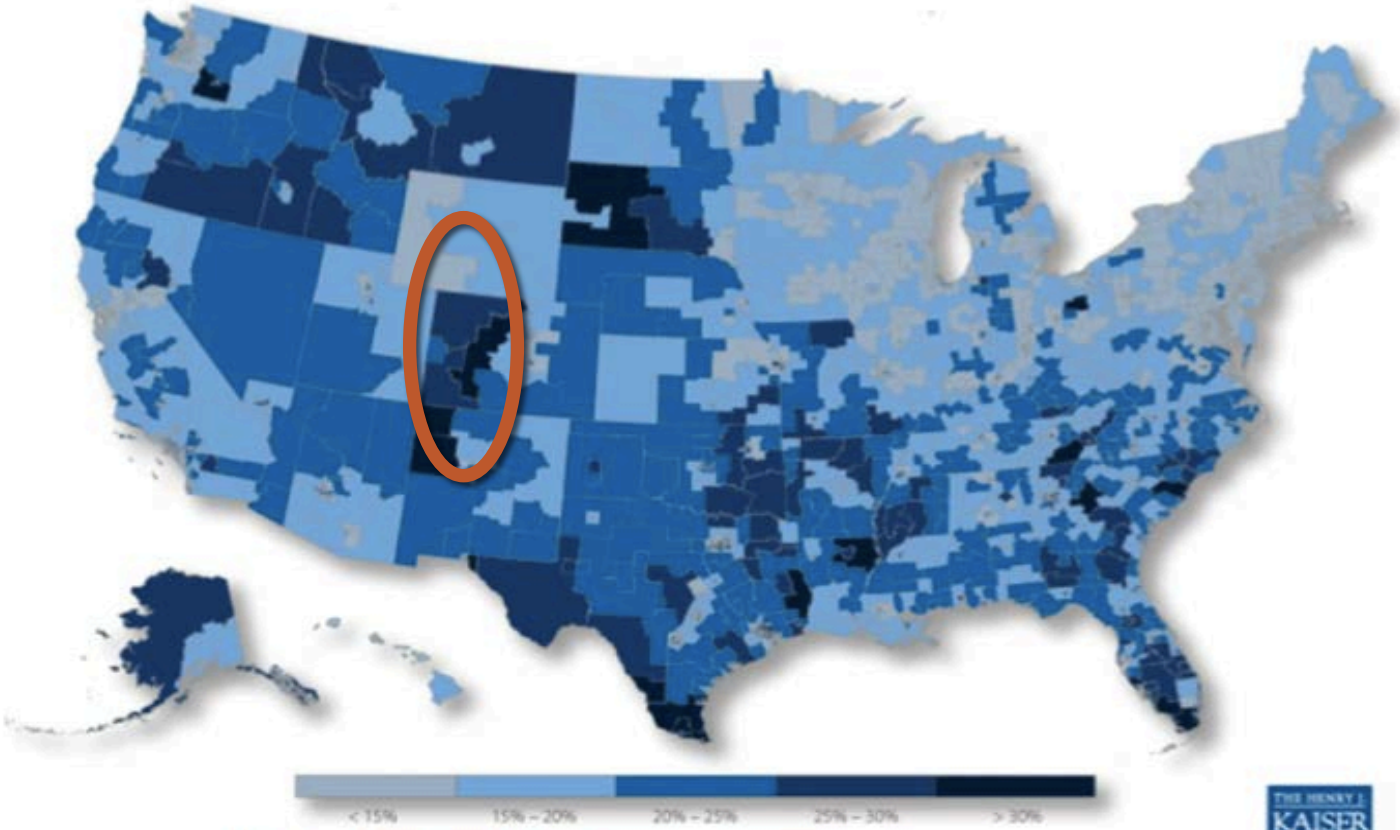


- Independent, 501c(4)
- Serving 350,000 people
- All types of health coverage – group, individual, self-funded, ACA, Medicare, and Medicaid
- Focused on Western Colorado
- Committed to health equity

RMHP = Rocky Mountain Health Plan; ACA = Affordable Care Act

Tough Demographics

- *Percentage of the nonelderly population with income up to four times the poverty level who were uninsured or purchasing individual coverage, 2010*



http://healthreform.kff.org/coverage-expansion-map.aspx

THE HENRY J. KAISER FAMILY FOUNDATION

RMHP's Primary Care Strategy: Bringing It All Together

Fully integrated, team-based practice

Connected to community, addressing all determinants

Advanced measures of value, predictive analytics, and feedback-driven data quality process

Clinician judgment and informed patient decision making

Non-volume, non-encounter, risk-adjusted payment and shared savings

Virtual clinic, asynchronous practice, care management

Multi-payer alignment: payment, measurement, data sharing

Advanced Practice Characteristics

Common Characteristics

- Persistence through multiple learning initiatives
- Active engagement in all facets of transformation
- Connection to external partners and supports
- PCMH recognition is common, but incidental to a broader process of change and leadership dynamics

Varying Characteristics

- Small, multi-spec, independent, hospital-owned, FQHC/RHC
- Multiple EHR platforms and configurations
- Patient volume – (100s to 1,000s of attributed members)
- Varying degrees of business competencies

PCMH = Patient-Centered Medical Home; FQHC = Federally-Qualified Health Center; RHC = rural health clinic; EHR = electronic health record.

Cost Outcomes

Substantial, independently evaluated TCOC differentials

Normalized for differences in population, demographics, risk and price

Medicaid	- 5.5%
Medicare	- 3.0%
Medicare-Medicaid Beneficiaries	- 5.4%
Commercial - Pending	
Combined	- 4.8%

TCOC = total cost of care.

Action items for better behavioral health: Scaling SHAPE

Behavioral health is a critical facet of comprehensive primary care — no different than investments in practice-based care management, measurement and other data use competencies, technology and practice transformation support.

Global payment based upon defined practice budgets for personnel, interventions and related infrastructure – to create team-based, whole-person care (e.g. CoACH)

Changing payment allows behavioral health providers to not be trapped in a workflow designed to maximize volume-based payments, or pigeon holed into distinct “physical” and “mental health” coding categories

Primary care practices “own” their own behavioral health resources and are fully accountable for measured outcomes

http://sustainingintegratedcare.net/
http://farleyhealthpolicycenter.org/cost-assessment-of-collaborative-healthcare/

Resources

One stop: http://integrationacademy.ahrq.gov/

SHAPE: http://sustainingintegratedcare.net/

Policy: http://farleyhealthpolicycenter.org

Case study: http://www.advancingcaretogether.org/

Webinars: http://www.youtube.com/CUDFMPolicyChannel

State example: http://coloradosim.org/

National organization: http://www.cfha.net/

More: http://www.pcpcc.org/behavioral-health

Email: Benjamin.miller@ucdenver.edu

Questions