Integration Innovation:

Initial Learnings from the SIM Bi-Directional Integration Pilot Program

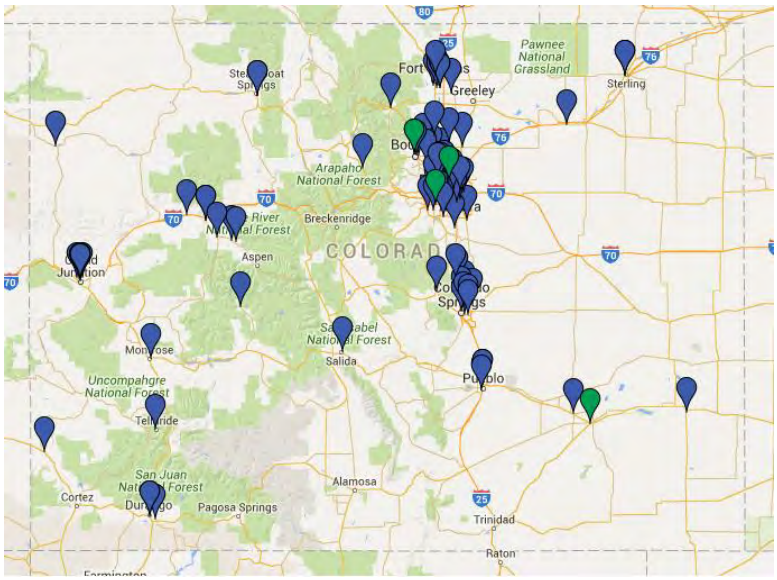
CBHC Annual Behavioral Health Training Conference Session
Beaver Run Resort and Conference Center
September 23, 2016
3:30 pm – 5:00 pm

Colorado State Innovation Model (SIM)

SIM is an initiative funded by the Centers for Medicare and Medicaid Innovation (CMMI) and strives to create a coordinated, accountable healthcare system that provides Coloradans access to integrated primary and behavioral health care.

The intent is to help current fee-for-service practices move from volume- to value-based care that considers all social determinants. The goal: Provide greater access to integrated physical and behavioral healthcare services in coordinated systems, with value-based payment structures, for 80% of Colorado residents by 2019. By the end of the project, SIM will involve 400 Colorado primary care practices and four community mental health centers (CMHC).

The Bi-Directional Integration Demonstration and Practice-Based Research Pilot Program is a component of Colorado's SIM plan. The Colorado Behavioral Healthcare Council (CBHC) was awarded funding by CMMI in partnership with the State of Colorado's SIM Office to facilitate the selection of four community mental health center (CMHC) sites to participate in the pilot program to integrate primary care and prevention services into the community behavioral health setting (bi-directional integration).



*SIM Transformation Map courtesy of the Colorado SIM Office. **Green** pins represent the CMHC pilot sites and **blue** pins represent the first 100 primary care practices. For more information on Colorado SIM, please visit www.coloradosim.org.*

For more information about the SIM bi-directional pilot program, please contact Emily Haller at ehaller@cbhc.org.

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Meet the Pilot Sites

Community Reach Center (CRC), a private, nonprofit community mental health center, is one of the premier integrated health providers in the north Denver area. For the bi-directional pilot program, CRC will partner with Salud Family Health Centers, a Federally Qualified Health Center serving communities in northeastern Colorado, and Dental Lifeline Network, a leading oral health provider. CRC and Salud have a strong history of collaboration and offer a highly developed system of integrated care. In December 2014, the three partners collaborated to place a medical clinic within the CRC Commerce City Outpatient Clinic. The SIM funding is transforming this clinic into a fully integrated health home. This pilot focuses on serving individuals in the Commerce City community with serious and persistent mental illness.

Jefferson Center for Mental Health (Jefferson Center) is the private, nonprofit community mental health center serving Jefferson, Gilpin, and Clear Creek counties. Jefferson Center is partnering with the Metro Community Provider Network (MCPN), the local Federally Qualified Health Center, and Arapahoe House, a premier substance use treatment provider, to create the Jefferson Plaza Family Health Home in Lakewood, Colorado. The three partner agencies have a strong history of collaboration on other integration projects – some spanning over two decades. This pilot project is helping to extend the current integration efforts to an even larger population. The Jefferson Plaza Family Health Home (JPFHH) primarily serves children and families who lack a primary care provider and would benefit from integrated care. This includes individuals with serious mental illness, serious emotional disorders, and substance use disorders, as well as those with less severe behavioral health needs. The JPFHH is also offering family health coaching and wellness services.

Mental Health Partners (MHP) is a private, nonprofit community mental health center that has provided mental healthcare for over 50 years to the local underserved population in Boulder and Broomfield counties. MHP will expand its long and successful partnership with Clinica Family Health Services, the local Federally Qualified Health Center, and its newer partnership with Dental Aid, a comprehensive dental care provider, to create the multi-agency collaborative, Boulder Health Integration Partners (BHIP). BHIP is leveraging funding from SIM and other sources to create a sustainable, integrated health home for adults with serious mental illness and/or co-occurring substance use disorders in the City of Boulder. And, through our collaborative partnership, we share a vision of creating a healthcare experience that is simple and seamless, inspires self-confidence and results in superior health and life outcomes for adults with serious behavioral health concerns. We will serve not only those who currently receive care but also the underserved in our community, such as Hispanic individuals, homeless individuals and those with cognitive impairments due to their mental health conditions.

Southeast Health Group (SHG) is the private, nonprofit community mental health center providing mental health, substance use, primary care, and wellness services to the six-county, rural and frontier region in the southeastern corner of Colorado, including the counties of Baca, Bent, Crowley, Kiowa, Otero, and Prowers. Since 2013, SHG has sustained a successful primary care program within its La Junta behavioral health home. The SIM pilot provides an opportunity for SHG to expand this integrated health home model across all six counties with access to bi-directional services in the La Junta, Rocky Ford, and Lamar offices. With the addition of another primary care team, SHG will reduce the wait list for primary care services from 3 weeks to 2 weeks. The SHG Integrated Health Home is targeting individuals living with one or more chronic health conditions, including a behavioral health disorder and is providing a full continuum of comprehensive physical health, behavioral health, and wellness services.

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.

SIM FRAMEWORK

DRAFT 7.27.15

SIM State Innovation Model

Payer & Public Program Functions

INTEGRATE

- Support to advance cohorts
- Research & development
- Linked financial management & IT systems
- Comprehensive payment models
- Scaling

Framework for Integration of Whole Person Care

- Integration
- Functions centralized across organizations
- Customized structures & processes

→ Full integration

System

COORDINATE

- Value-based & other enhanced payments
- Coordinated enterprise initiatives
- Shared accountability
- Linked services/care
- Data sharing
- Aligned measurement

- Inter-organizational arrangements
- Aligned arrangements

→ Prompt Access to Care, Including BH

→ Comprehensive & Coordinated Care Across PC & BH

- Market & network-based

→ Patient-team Partnership

→ Population Management

→ Community of Care Linked to BH & Social Supports

Organization

COOPERATE

- Multiple organizations & grants
- Extension service framework
- Broad-based "on ramp"
- Cross sector & institution cooperation
- Enterprise specific initiatives

→ Engaged Leadership Supportive of Integration & Change

→ Data-driven Improvement

→ Empanelment

→ Team-based Care

Clinic

Population — Person — Population

The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.

Adapted from: Bodenheimer T, Willard-Grace R, Ghorob A, Grumbach K. "The 10 building blocks of high-performing primary care." Ann Fam Med. 2014;12(2):166-171. http://www.annfammed.org/content/12/2/166.full.pdf

Comprehensive Primary Care Practice Monitor
Mental Health Center Version, 2-22-16

Please consider how fully each item has been implemented or functions in the portion of your Mental Health Center that provides integrated primary care services (referred to here as the "practice"). Fill in the circle that best reflects the completeness of implementation in your practice. If you rate something as a 4, it means it is now routine across the entire practice. A rating of 1, 2, or 3 means that the statement is only done sometimes, or only in part, or not by everyone in the practice.

1. ENGAGED LEADERSHIP	**Not at all ▼**				**Completely ▼**
a. Practice leaders support innovation and are willing to take risks and tolerate occasional failures in order to improve	⓪	①	②	③	④
b. A culture of shared leadership has been created, with everyone sharing responsibility for change and improvement in the practice	⓪	①	②	③	④
c. The practice has a shared vision for practice transformation that everyone understands and supports.	⓪	①	②	③	④
d. Practice leaders proactively remove organizational barriers to change and improvement	⓪	①	②	③	④

2A. QI PROCESS	**Not at all ▼**				**Completely ▼**
a. Our practice has a sustainable, effective quality improvement team that meets regularly and deals effectively with challenges	⓪	①	②	③	④
b. QI team meetings are well-organized, with agendas, meeting summaries, prepared leaders and members.	⓪	①	②	③	④
c. The QI team uses QI tools effectively – AIM statements, process mapping, PDSA.	⓪	①	②	③	④
d. QI team members reliably follow-up on assignments and tasks, with good team accountability.	⓪	①	②	③	④
e. Staff members are actively and regularly involved in QI team meetings	⓪	①	②	③	④

2B. DATA DRIVEN IMPROVEMENT	**Not at all ▼**				**Completely ▼**
a. Clean and accurate quality measurement data are available for targeted conditions.	⓪	①	②	③	④
b. We are able to extract data from our medical record systems for registries (lists of patients with particular conditions and with key information about those patients)	⓪	①	②	③	④
c. Workflows for maintaining accurate registry data have been reliably implemented.	⓪	①	②	③	④
d. Quality measures and other data are used as a central area of focus for the practice's improvement activities.	⓪	①	②	③	④

3. EMPANELMENT OF PRIMARY CARE PATIENTS	Not at all ▼				Completely ▼
a. Our practice has an ongoing, reliable system for empanelment and panel management within our data systems and practice processes.	⓪	①	②	③	④
b. Each primary care patient is assigned a personal primary care clinician, with a small team to serve as back-up when the personal clinician is unavailable	⓪	①	②	③	④
c. Patient panels are used as a foundation for population health management	⓪	①	②	③	④
4. TEAM-BASED CARE	**Not at all ▼**				**Completely ▼**
a. Care teams have been designated and have regular team meetings	⓪	①	②	③	④
b. Standardized protocols and standing orders have been created to maximize the efficiency of the practice workflow	⓪	①	②	③	④
c. Team members have defined roles that makes optimal use of their training and skill sets	⓪	①	②	③	④
d. Team huddles are used to discuss patient load for the day and to plan for patient visits	⓪	①	②	③	④
5. PATIENT-TEAM PARTNERSHIP	**Not at all ▼**				**Completely ▼**
a. A system has been implemented for including patient and family input in ongoing improvement activities (such as patient advisory groups or patients and family members on QI teams)	⓪	①	②	③	④
b. A patient experience survey is administered regularly (monthly or quarterly) and the data used to monitor and improve practice performance	⓪	①	②	③	④
c. Patients and families are actively linked with community resources to assist with their self-management goals.	⓪	①	②	③	④
d. Patients and families are provided with tools and resources to help them engage in the management of their health between office visits	⓪	①	②	③	④
e. Personalized shared care plans are developed collaboratively with patients and families	⓪	①	②	③	④
f. Personalized shared care plans are regularly reviewed to monitor patient progress in accomplishing their goals and adjusted when appropriate	⓪	①	②	③	④
g. Our practice has implemented and regularly uses shared decision making tools or aids for at least two health conditions, decisions, or tests	⓪	①	②	③	④
6. POPULATION MANAGEMENT	**Not at all ▼**				**Completely ▼**
a. Our practice uses a standardized method or algorithm for identifying its high risk patients	⓪	①	②	③	④
b. Patients with care or outcomes falling outside of guidelines are identified for more intensive care	⓪	①	②	③	④
c. Our practice has a patient recall system to identify and bring in patients for needed care	⓪	①	②	③	④

d. Our practice provides care management services for patients and families identified as being high risk or needing additional assistance and/or contact between visits	⓪ ① ② ③ ④
e. Our practice links patients to community resources to address social determinants of health (such as housing, food security, transportation, legal assistance, help paying bills, personal safety)	⓪ ① ② ③ ④
f. Our practice engages with public health or community organizations to make improvements in mutual population health goals	⓪ ① ② ③ ④
7. CONTINUITY OF CARE	**Not at all ▼ Completely ▼**
a. Our practice has a system to insure that patients are able to see their own primary care clinician as often as possible	⓪ ① ② ③ ④
b. Our practice tracks the percentage of patient visits that are with the patient's primary care clinician	⓪ ① ② ③ ④
8. PROMPT ACCESS TO CARE	**Not at all ▼ Completely ▼**
a. Patients and families can reliably access care from or coordinated by our practice after hours or on weekends	⓪ ① ② ③ ④
b. Patients and families can reliably and quickly access their personal clinician or a care team member to answer questions or deal with problems	⓪ ① ② ③ ④
c. Patients can reliably make an appointment with their personal clinician or a care team member within defined and acceptable time periods	⓪ ① ② ③ ④
9. CARE COORDINATION	**Not at all ▼ Completely ▼**
a. A structured system is in place for assuring appropriate follow-up and care planning for patients undergoing transitions of care (such as discharge from hospital, ER visit, etc.)	⓪ ① ② ③ ④
b. Collaborative agreements such as care compacts have been developed with key specialists and community resources for communication, coordination of care, and handoffs	⓪ ① ② ③ ④
c. Our practice communicates actively with specialists and community resources to coordinate care based on the patient's personalized shared care plan	⓪ ① ② ③ ④
10. RESOURCE UTILIZATION & COMPENSATION REFORM	**Not at all ▼ Completely ▼**
a. The cost of care is discussed with patients and families as a factor in choosing between care options	⓪ ① ② ③ ④
b. The practice uses cost of care data in QI activities to improve patient resource utilization	⓪ ① ② ③ ④
c. Our practice can track payments from various sources, including those not from fee for service, and allocate the revenues to the services provided	⓪ ① ② ③ ④
d. Our practice regularly compares and reconciles payer attribution lists with our patient panels	⓪ ① ② ③ ④
e. Our practice considers cost and quality of care when choosing where to refer our patients	⓪ ① ② ③ ④

11. PRIMARY CARE AND BEHAVIORAL HEALTH INTEGRATION ***Note: "Behavioral health" includes mental health, health behavior change, and substance abuse services.***	**Not at all ▼**				**Completely ▼**
a. Our practice is actively working to improve our care of physical health conditions.	⓪	①	②	③	④
b. An effective system has been implemented to identify patients with physical health conditions or concerns and assure that they receive care either in our center or in another setting	⓪	①	②	③	④
c. We have an effective system to help us identify whether a client has a relationship with a primary care clinician and, if so, to assure that our care is coordinated with that clinician	⓪	①	②	③	④
d. We have defined the physical health conditions that we will particularly target for quality improvement, population management, and/or care management.	⓪	①	②	③	④
e. We educate all patients and their family members on the benefits of integrated behavioral health and primary care	⓪	①	②	③	④
f. We have an effective system for identifying and assisting patients with chronic physical health issues who are not improving with treatment	⓪	①	②	③	④
g. We have an effective system for identifying and following up with patients with physical health issues who do not follow through with planned visits	⓪	①	②	③	④
h. Protocols and work flows have been implemented for coordination between primary care and behavioral health clinicians	⓪	①	②	③	④
i. Our primary care staff clinicians work closely as a team with the behavioral health staff and clinicians to provide integrated care	⓪	①	②	③	④
j. Our practice utilizes warm handoffs and close collaboration between onsite primary care and behavioral health providers	⓪	①	②	③	④
k. Training on integrated care is provided to all clinicians and staff joining our center	⓪	①	②	③	④
l. We have developed collaborative agreements such as care compacts with external specialty behavioral health clinicians and medical specialists, covering timely access, communication, handoffs, and coordination of services	⓪	①	②	③	④
m. We systematically collect data to track the reach and outcomes of our integrated primary care services	⓪	①	②	③	④

Center name: _____

Date Monitor completed: _____

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Session Handouts

- Overview of the Colorado SIM Program and Pilot Sites
- Colorado SIM Practice Milestones
- SIM Framework and Building Blocks
- Practice Monitor: Community Mental Health Center Version

Additional Resources

- Colorado SIM Office
  www.coloradosim.org

- Practice Innovation Program Colorado
  www.practiceinnovationco.org

- Integrated Practice Assessment Tool (IPAT)
  http://www.integration.samhsa.gov/operations-administration/IPAT_v_2.0_FINAL.pdf

- Vermont Practice Integration Profile
  https://redcap.uvm.edu/redcap/surveys/?s=vEpGbwyFE6

- Behavioral Health Integration Capacity Assessment Tool (BHICA)
  https://www.resourcesforintegratedcare.com/tool/bhica

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