CBHC
Colorado Behavioral Healthcare Council

An Innovative Model for Integrated Care

A Guide for Community Mental Health Centers Interested in Adopting Integrated Care

Program Introduction

In 2015, the Colorado Behavioral Healthcare Council (CBHC) began a partnership with the Colorado State Innovation Model (SIM) office to facilitate and manage the Bi-Directional Integration Demonstration and Practice-Based Research Pilot Program, a key component of Colorado's SIM plan designed to integrate primary care and prevention services into the community behavioral health setting. Colorado's community mental health centers (CMHCs) believe in treating the whole person, and as such, four of these centers were selected to begin piloting models of bi-directional integrated care. These programs, which concluded in July of 2019, have shown that offering a full array of health care under one roof can change the course of an individual's overall wellbeing for the better.

The four participating sites were independently selected to begin work on their integrated health homes in 2015.

Community REACH Center

Mental Health PARTNERS

Jefferson Center

SOUTHEAST HEALTH GROUP

The goals for this model are aligned with the entirety of the SIM program:

"to improve the health of Coloradans by increasing access to integrated physical and behavioral healthcare services in coordinated community systems, with value-based payment structures, for 80 percent of state residents by 2019."

Key Implementation Strategies

- **Streamlining integrated care delivery amongst all four of the CMHCs**

  To demonstrate their commitment to delivering quality services, each of the four sites developed extensive workflows and processes to support the delivery of integrated care.

- **Creating essential, unified partnerships to support sustainability**

  The three CMHCs that partnered with a federally qualified health center (FQHC) for delivery of primary care services all cited that investing time into building a quality partnership was by far the most important aspect in sustaining integrated care.

- **Designing an appropriate staffing structure**

  Delivering integrated care requires more than hiring a behavioral health provider and a primary care provider. In addition to having providers on staff, specialized teams were created, which included care coordinators, health coaches, peers, front desk staff, nurses, medical assistants, certified coders, billing staff, and everyone in between. The Centers found the greatest success by training front desk personnel on the importance and nuances of integrated care to create a welcoming environment of trust and compassion amongst all staff. This also encouraged a culture of continuous improvement to advance the delivery of integrated care to each individual patient.

Notable Accomplishments

- **Clients receiving integrated care through SIM demonstrated notable health improvements.**
  - CMHCs that reported both baseline and follow up data demonstrated statistically significant improvement in "overall symptom severity" as measured by the Colorado Client Assessment Record (CCAR).
  - All four CMHCs experienced improvements in depression screening and management.
  - All four CMHCs experienced improvements in Hemoglobin AIC screening and control.
- **All four CMHCs experienced an increase in overall integration scores, from 71% to 90% (which was higher than the primary care practices).**
- **All four CMHCs demonstrated increased ability to report on clinical quality measures and improved data usage and health information technology functionality.**
- **As shown in the table below, the four CMHCs participating in SIM demonstrated significant return on investment and healthcare savings to all payers (Commercial, Medicaid, and Medicare).**

Line of Business	Projected PMPM	Actual PMPM	Savings PMPM	Member Months	Total Savings
2016					
Commercial	$457.92	$447.14	$10.52	9,624	$101,220
Medicaid	$683.25	$661.44	$21.80	169,516	$3,696,023
Medicare	$1,882.88	$1,770.93	$111.95	25,915	$2,901,065
2016 TOTAL	**$824.28**	**$791.62**	**$32.67**	**205,055**	**$6,698,308**
2017					
Commercial	$549.47	$490.70	$58.77	8,992	$528,427
Medicaid	$705.92	$655.71	$50.21	164,464	$8,258,115
Medicare	$2,135.68	$1,795.04	$340.64	28,127	$9,581,321
2017 TOTAL	**$898.44**	**$807.32**	**$91.12**	**201,583**	**$18,367,863**

Project Costs and Total Cost Savings Per Member Per Month (PMPM)

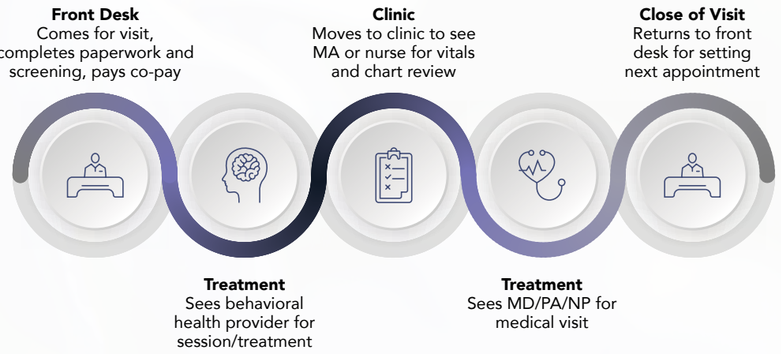
Overall Program Structure

Three of the CMHCs in this project created their clinics by partnering with a federally qualified health center. The fourth hired their own primary care staff. Integrating services into a mental health and primary care system requires a series of major operational adaptations including workforce, administration, clinical operations, and more. Building and sustaining integrated care means all parts of the organization must reflect the values of whole-person care, and the understanding that successful clinical outcomes are everyone's responsibility.

CMHCs made investments with SIM dollars in several key areas:

- **Data collection, integration, and aggregation**
- **Workflow and process redesign**
- **Technology**
- **Team training and support**
- **Clinic space redesign and build out**
- **Prescriber services**
- **Financial modeling**
- **Quality improvement**
- **Research**
- **Risk stratification development**
- **Consultation services focused on team-based care and shared decision-making**
- **Dental screening services were provided by some of the sites**

How a Patient Flows Through the Clinic



Workflows Within the Community Mental Health Centers

To make integrated care successful, all participants must be willing to redesign their core processes to create and sustain a system of care that is person-centered. Each CMHC structured their health home differently, which resulted in myriad workflow strategies.

Common workflow structures included:

- **Appointment scheduling**
  Ensuring adequate appointment times for patients who need more services during each visit.
- **MA/Nurse/front office roles (pre-visit, vitals, agenda setting, checking chronic and preventive care needs, ordering)**
  Ensuring the appropriate training of all front office staff in the methodology of integrated care to ensure consistency throughout the entirety of a patient visit.
- **Multi-disciplinary care team communication (which messages go to whom, what action is required)**
  In the absence of fully integrated electronic medical records, workflows for cross-departmental communication are critical.
- **Prescription refills (chronic meds, acute meds, secure script meds)**
- **Billing**
  One clinic hired a certified coder to establish workflows to provide consistency in how all providers in the clinic billed for services, which resulted in significant reclamation of revenue.
- **Risk stratification**
  Ensuring use and efficacy of risk stratification models once they are designed and implemented.
- **Healthy/preventive care**
  Creating systems for engaging patients in preventive healthcare.
- **Managing chronic conditions (diabetes, hypertension, congestive heart failure)**
  As group sessions have proven vital in the integrated care setting, workflows for identifying patients who would benefit from chronic condition group sessions were established.
- **IT**
  Ensuring accurate collection, documentation, and evaluation of data.

Consumers will often provide different pieces of their story (needs/wants from the visit or in general) to the multiple people they see in the clinic.

It's the clinic's role to consolidate that information into a whole picture, whether through charting immediately or a quick hallway huddle.

Implementation Observations: Length of Visit

High-need populations

Most CMHCs found that 40+ minute appointment times are more appropriate for addressing key issues than shorter (20-minute) appointments and resulted in better outcomes. Due to the challenge of sustaining longer appointments, creative strategies such as more group visits and having an MA or nurse do the first 20 minutes followed by the provider for the last 20 minutes have proved to be effective solutions. Risk stratification was also useful in understanding who needs longer appointment times.

It should also be noted that in addition to group visits helping make the longer visits sustainable, diabetes group visits have been successful in building strong, accountable peer support networks. A group visit model was developed by combining one group from the partnering FQHC and one from the CMHC, which resulted in a model that centers on the patient to ensure better patient outcomes.

Implementation Observations: Group Sessions

Groups are incredibly beneficial to individuals who may be feeling alone as they walk through their journey of healing. They enable consumers to find a community of support while also offering financially sustainable solutions for CMHCs.

Group sessions case study

One CMHC started a diabetes care group for their consumers with dual diagnoses of diabetes and SPMI but found that SPMI population somewhat challenging because of persistent attendance issues. To encourage participation, the CMHC provided the group members access to both the medical and behavioral health care staff, giving the group a combination of education relating to diabetes care and peer-to-peer support.

This included discussions about diet and affordable nutrition, how to eat well on a low income, participating in exercise opportunities such as walks, and other relevant topics. Because the group included two different providers, they were able to provide wrap-around services addressing more than just the medical issue while simultaneously realizing the benefit of all participating consumers lowering their A1c.

Implementation Observations: Risk Stratification

An effective risk stratification model provides an additional mechanism for extracting data about consumers, not only individually, but at an organizational and community-based level. Reports assist in decision making:

- **The organization can determine the average acuity of each patient**
- **The organization can more simply monitor patient risk improvement and assess what interventions/ levels of contact are most effective**
- **Clinician recruitment can occur based on their risk level skill set to reduce turnover and burnout**
- **Risk reports can be community specific (by consumer address) to see if communities are stable, stabilizing, or decompensating. For example: administration can now strategize for community intervention during increased deployment of military members, thus anticipating the needs of their families in their absence**

Risk stratification case study

A risk stratification model was implemented, encompassing the entire health home (i.e., behavioral health, primary care, and physical therapy), with all existing and new patients assessed. After nine months of service data, they were able to connect the number of contacts and the types of services that appeared to be a best practice, and medically necessary, to create care recommendations by risk level.

As the individual levels are evaluated by the number of patients attributed, therapist caseloads are balanced or specialized. This CMHC has stopped following the model that every clinician's caseload should be between 45-55 patients and instead determines caseload by evaluating the patient's risk factor and the clinician's interests/skillset.

Example: Clinician X should not have 60 patients at high risk (scale of 4-6), because the number of contacts suggested would be overwhelming for Clinician X to achieve. Instead, one of two options would occur:

1. Clinician X is great at serving high-risk patients, so the caseload would be reduced to 20-25 of the high-risk patients already assigned; or
2. Clinician X is great at serving lower-risk patients, so the caseload number would stay close to the same, but the caseload would be reexamined to only include patients who scored a risk score of 3 or lower to balance the caseload.

This CMHC also discovered that tracking risk stratification and applying risk levels to determine appropriate intervention was helpful for evaluating patient success.

Developing and Understanding Integrated Care Teams

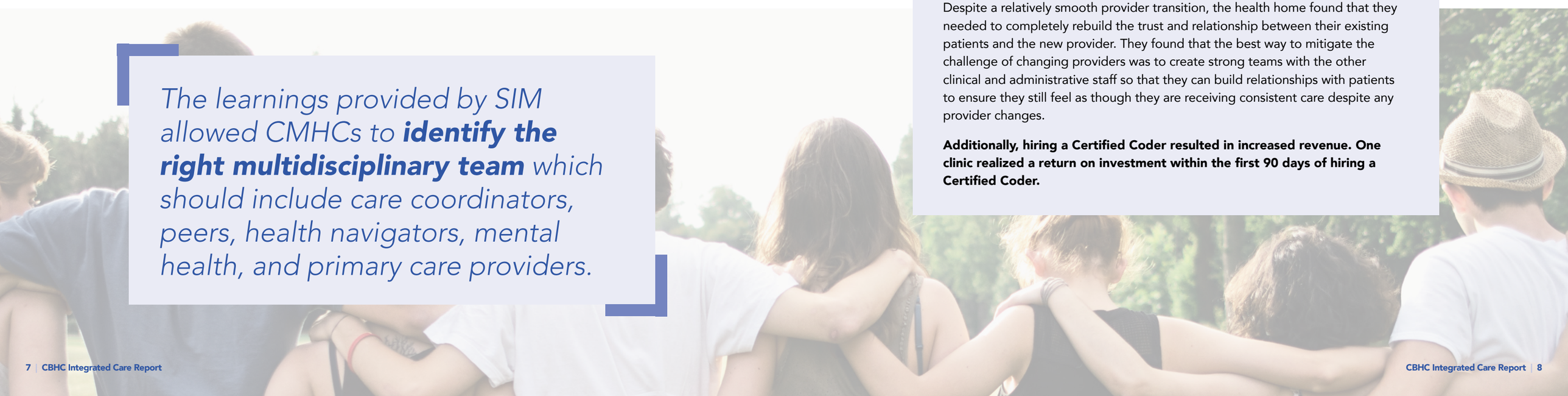
The essential element of creating a successful and sustainable integrated care program was developing a healthy partnership between the primary and mental health care entities. This partnership relied on two core components: leadership and organizational commitment to integrated care, and a shared vision for successful outcomes regarding patients that may have complex behavioral health and primary care needs.

Effective partnerships were able to communicate that the organization was committed to delivering "the right care" for their consumers, despite the reality that the funding had not evolved to match the model of whole-person care. This required trusting in the potential for success, a belief that funding systems would eventually catch up, and the leadership of both organizations maintaining a commitment to each other's financial success. Many clinics reported the importance of developing shared outcomes to demonstrate the power of this model of care and to show that they could do more together than either can do alone.

All organizations – mental health centers and primary care practices – articulated how changes in payment or policies at a state level tests their commitment and ability to partner: "Funding can reinforce or instill competition and can fracture systems and diffuse funding, thus negatively impacting the quality of care being delivered." Leadership identified the tenuous balance between innovation for improving outcomes through integration versus the stark reality of funding. Many CMHCs have looked at visit structures or risk stratification to address payment challenges. This funding issue is one of the greatest threats to the sustainability of integration.

Several centers scheduled regular team meetings between leadership, operations, and clinical departments to develop and adjust the integrated care model, oversee team development, assess who does what, and resolve issues. Many mental health and primary care providers indicated the importance of a relationship starting years before this effort in allowing this model to continue beyond staff departures.

All teams developed a formal structure to review patient care and integrated treatment plans, focusing on clinical case reviews and evaluations of individualized clinical progress. The format varied between weekly or biweekly team meetings, daily huddles, or a mixture of both. Clinics also reflected on the importance of hiring the right providers, as not all healthcare providers are suited for team-based care and high-needs populations. It is important that the match between the model and the provider is carefully considered.



*The learnings provided by SIM allowed CMHCs to **identify the right multidisciplinary team** which should include care coordinators, peers, health navigators, mental health, and primary care providers.*

Staffing

In addition to the right workflow, identifying the right team members to make integration successful is critical. While leadership buy-in is necessary, positions in each organization focused solely on management and learning related to integration is essential.

Successful integration requires:

Behavioral health

- Program manager to provide support/relief/back-up as needed, supervise the team and work with other teams throughout the agency
- Psychiatrist
- Psychiatric nurse and nursing assistant
- Behavioral health professional
- Care coordinators
- Peer support specialists
- Front desk staff: This role greatly supported schedule management and capitalizes on a unique perspective and knowledge of clients and staff.

Primary care

- PCPs (more than one)
- Medical assistants (more than one)
- Primary care nurse: essential for client care, continuity and team-building
- Front desk: the customer service expertise in this role is also critical.

Dental (ideal if the opportunity is available)

- Dental hygienist
- Dental case manager

Staffing case study

One lesson learned was to realize the importance of the relationships built between providers and patients. One CMHC had their PCP retire in 2017 and relied on interim providers until a permanent PCP was found as a replacement. Despite a relatively smooth provider transition, the health home found that they needed to completely rebuild the trust and relationship between their existing patients and the new provider. They found that the best way to mitigate the challenge of changing providers was to create strong teams with the other clinical and administrative staff so that they can build relationships with patients to ensure they still feel as though they are receiving consistent care despite any provider changes.

Additionally, hiring a Certified Coder resulted in increased revenue. One clinic realized a return on investment within the first 90 days of hiring a Certified Coder.

Partnerships include:

- **Local public health agencies**
  To provide community education in partnership with the CMHC about the services provided and population health information.

- **Local recreation centers**
  To provide free passes to health home consumers to encourage wellness activities.

- **Food and housing agencies**
  To provide joint events in order to share information about resources.

Community Partnerships

One realization is that, regardless of the community partner, taking time to learn about each other's cultures is worth the effort. Exploring similarities and differences between the way each partner operates and the values that drive them enhances working relationships and creates a stronger connection.

Other community agency partnerships

Strong, ongoing partnerships with community agencies that can come to the health home and provide resources directly to consumers have proven to be invaluable.

Data Sharing and Documentation

Health Information Technology data sharing is one of the biggest challenges to integration. CMHCs and primary care practices must find creative, compliant ways to share patient information.

Within a partnership

For integrated care to work, clinicians must have access to information about the patient regardless of where they received previous care. While participants invested in IT systems and decision support mechanisms, and all four CMHC's have some level of shared health records, they have not become fully integrated and the ideal of shared electronic health records are yet to reach fulfillment. In the face of these barriers, the CMHCs invested time into developing workflows that would allow for cross-communication between providers as an interim solution. Some of those workarounds included:

- **Hiring care coordinators to bridge the information gap between the behavioral and physical health providers by accessing both sets of electronic health records, acting as an intermediary and ensuring there were no gaps in care.**
- **Utilizing spreadsheets to capture data on clinical quality measures from both electronic medical records systems.**
- **Printing chart notes for huddles so that both providers would be able to access all information on each patient.**
- **Creating cloud-based data warehouses where the patient's providers could access critical patient data independently of the records systems.**

One CMHC that partnered with an FQHC created a workgroup of key information systems staff from each agency, including the business intelligence director, VP of Strategy, Information Systems VP and data analysts, along with the health home manager or director. This group identified which data elements would be exchanged via an automatic nightly upload from the CMHC to the FQHC, created a data export from the FQHC to the CMHC and began discussions of longer-term data sharing solutions. They addressed confidentiality concerns by signing a confidentiality agreement early in the process of their partnership and developing a secure file transfer protocol (SFTP) to enable the file transfers.

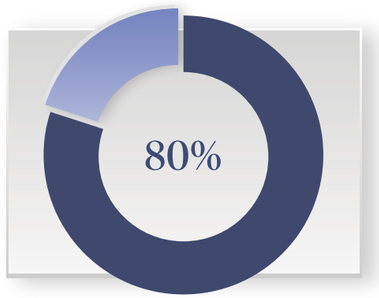
SIM Bi-Directional Integration

... Numbers and Facts

SIM demonstrated that community mental health centers are an appropriate health care home for patients with complex health care needs.

SIM helped achieve Triple Aim outcomes:

1. Enhanced Population Health
2. Reduced Cost
3. Improved Patient Experience of Care



Overarching Goal

Improve the health of Coloradans by providing access to **integrated primary care and behavioral health services** in coordinated community systems, with value-based payment structures, for **80-percent of state residents by 2019**.

Up to $65 Million Awarded

to test its State Healthcare Innovation Plan: a bold plan for integrating physical and behavioral health care in more than

400 primary care practices and community mental health centers

1600 primary care providers

1 in 5

adults in the U.S. have a mental health condition

Nearly 20%

of Colorado residents are living with some type of mental illness.[2]

CO

In 2018, Colorado ranked number 10 of all U.S. states challenged with access to care. SIM worked to increase access through integrated care.[3]

CBHC Colorado Behavioral Healthcare Council

Mental Health PARTNERS

Jefferson Center

Community REACH Center

SOUTHEAST HEALTH GROUP

At the start of the SIM initiative in 2015,

MORE THAN 50%

of Coloradans surveyed reported cost as a key barrier to treatment[1]

Actuarial Projections From July 2019 Found

Projected healthcare cost savings of **$178.6 million**

Projected Return on Investment of **7.47%**

Source: Milliman, Inc. (July, 2019). SIM Healthcare Cost Savings and Return-on-Investment Report

This is based on a $6.76 million investment of CMMI and other payers in the Colorado SIM for the Community Mental Health Centers

[1] 2015 Colorado Health Access Survey
[2] Substance Abuse and Mental Health Services Administration report 19.55%)
[3] www.mentalhealthamerica.net/issues/state-mental-health-america-2018

Notable Observations and Key Recommendations for Implementation

CMHCs Play a Critical Role as Health Homes

CMHCs can build on the experiences of SIM to meet the whole health needs of clients.

For many adults and children with behavioral health disorders, community mental health centers are their principle source of health care. Through the SIM initiative the four participating CMHCs provided integrated care and health promotion services to thousands of clients, many of whom previously lacked a primary care provider. The CMHCs were able to break down barriers to care such as transportation and stigma by offering comprehensive integrated care. The patient experience of care was improved because they had clinicians and care teams with whom they felt comfortable, who had experience working with the targeted populations, and with whom they had built trust over time.

Colorado SIM Framework and Milestones Help CMHCs Successfully Integrate Care

CMHCs can use these milestones as a step-by-step process towards integration and to better understand how primary care works.

The Colorado SIM framework and milestones are directed at primary care practices working to integrate behavioral health into their medical clinic. Therefore, it is recommended that these milestones be used by CMHCs, as they are specific and work as a step-by-step process toward integration. They also help CMHCs understand how primary care works. The milestones that don't fit exactly can still be used as a guide for moving along the integration continuum, though this can be a time-consuming process.

A Quality Improvement Opportunity

CMHCs can use primary care integration and partnerships to improve processes and methodologies to implement QI processes, including better data and analytics collection and insights.

Quality improvement (QI) starts with a healthcare organization's underlying systems of care, and training employees on QI processes is critical to maintaining consistency. In the beginning of the SIM grant, Practice Facilitators worked with each CMHC to conduct staff training on creating effective teams and met with leadership from each partner organization to review the quality improvement process and expectations for their participation.

This proved to be vital as it set the stage for both mental health and physical health entities to create workflows using the same processes and methodologies for a smooth transition to integrated care. Many of the practices used the Plan-Do-Study-Act (PDSA) cycles to test a CQI initiative so that the changes were rapidly deployed and disseminated.

Quality improvement can't happen without constant measurement and evaluation. Providing QI teams with analytics requires investments in data collection related to quality metrics. The transparency that results from this measurement and evaluation encourages improvement by empowering CMHCs and their partners to better assess quality of care, cost and patient experience.

Be Prepared to Address Staffing Challenges

Turnover is inevitable, and the impacts are amplified when new staff members must understand and incorporate the intricacies of integrated care. Mitigate these challenges through extensive communication policies and mapping of workflows for data and clinical operations.

Staff turnover was a consistent challenge amongst all four of the CMHCs. Since many of the roles in the CMHCs tend to be looked at as "stepping stones" into a deeper career in behavioral health, many positions had to be filled and refilled over the course of the SIM grant. This meant that the CMHCs were constantly training new hires and trying to maintain the cohesiveness of the integrated care team.

The training of new staff members to understand and incorporate the model of integrated care often took a significant amount of time, especially if the new staff member was not familiar with the model. They often found that if new staff were struggling to understand the intricacies of integrated care, miscommunications occurred, and the operational flow of the clinic was interrupted. This was additionally complicated for the CMHCs who were partnering with an FQHC as new staff needed to learn not one but two operational systems and how they intertwined.

CHMCs mitigated these challenges through extensive communication policies that appeared to increase the ease of transformation and streamlined the process of onboarding new staff. This also included the mapping of workflows for data and clinical operations.

Implement Ongoing Training

Training must go beyond new staff and new programs. Reinforce and expand your team's abilities in integration through regular designed training programs such as Lunch and Learns.

Ensuring staff continues to be trained in integration is an important piece of sustainability. New staff certainly need to be trained on how an integrated clinic works differently, but long-term staff also need to receive updated information and they should have the opportunity to provide feedback into the processes and workflows of the clinic.

Lunch and Learns are a great way to provide ongoing training. One CMHC held bi-monthly sessions: the first session was didactic learning, sometimes with an outside speaker, on a specific topic; the second session was data review used to create specific, action-oriented plans to meet those needs. Lunch and Learns can also be recorded so staff who could not attend can still learn, and a library of resources for future training needs can be built.

Notable Observations and Key Recommendations for Implementation

Anticipate Data Sharing Challenges

The electronic health records used by behavioral and primary healthcare providers are not yet integrated. The CMHCs found it necessary to invest in sustainable workarounds such as manually integrated spreadsheets, printed chart notes for team meetings, and shared data warehouses.

Data sharing was an ongoing challenge that all four CMHCs encountered during the SIM program. Despite the growing dedication to integrated care in Colorado's behavioral healthcare system, electronic health records have yet to catch up.

The CMHCs found it difficult to deliver integrated care without having systems that were interoperable. This is highlighted by the fact that all four centers were required to create new workflows for documenting and sharing electronic medical records (EMRs) between the behavioral health and physical health providers. Each worked with two separate electronic medical records and found that bridging the gap between them was a barrier that they could not overcome themselves.

Despite this, the centers did create sustainable workarounds that enabled them to continue providing integrated care while documenting and capturing critical data within their agency. Some of those workarounds were:

- **Utilizing spreadsheets to capture clinical quality measure data from both EMRs**
- **Printing chart notes out for huddles so that both providers would be able to access all information on each patient**
- **Creating data warehouses to begin housing critical patient data that could be accessed independently of the EMRs by the patient's providers**

Explore Data Warehousing Carefully

A key factor for these programs was to invest the time needed up front to obtain buy-in from leadership on both sides and to explore how the two data sets aligned. They developed workarounds to share information and data electronically despite having separate electronic health records.

Starting slow with a data warehouse was key. It was important to create clear understanding between partners about what data should be shared and make sure leadership on both sides were willing to make it happen.

Next, the CMHCs had to be sure there was a strong confidentiality and data sharing agreement in place, addressing issues such as HIPAA and 42 CFR Part 2.

One CMHC initially shared data through encrypted emails of spreadsheets. They recommended this as a way to start because changes and gaps can be addressed and fixed easily on a spreadsheet. Then, once the information flow is exactly how each entity needs and wants it to be, queries and code can be written with those specifics, so the electronic flow is exactly what is required.

Get Creative to Address Financial Barriers

Finances are often the biggest barrier to adding services. Through this project, the CMHCs uncovered a number of general recommendations that can help:

1. **Bill for everything that is allowed. Make sure your staff is well trained on what can be billed for, and which codes to use.**
2. **Know your Medicaid payment structure well, including services you can provide through capitation, as well as fee-for-service.**
3. **Find ways to encourage consumers with commercial insurance to use your CMHC. You might need to have separate clinicians who see those consumers, have a different intake process, set aside one particular building, etc. Creativity may be the key here.**
4. **Partner in your community to provide comprehensive services or find an unmet need your community has and fill the gap.**
5. **CMHCs should advocate with payers for a payment methodology that is inclusive of care coordination, care management, and health screening at a minimum.**

Consider Help from Consultants

A consultant can offer a lot of value, especially when you're getting started.

For CMHCs working toward integration, the Practice Facilitator position can be helpful, particularly at the beginning of the process. If your agency feels a consultant would be helpful in starting your integration journey, it is recommended that you add a consultant, for a short time, with a specific agenda and a list of what you want to accomplish with that consultant.

Consider Co-location First

Integration doesn't have to be a daunting task, but it is important to understand limitations when starting out. Co-location can be a great first step in creating a larger health care home over time.

If starting a fully integrated clinic feels like too daunting of a task, begin with building primary care partnerships. Internally discuss how you need the program to look regarding staffing and revenue, then reach out and offer to place a behavioral health provider in clinics to provide behavioral health care. Have contracts and Memorandums of Understanding at the ready regarding data sharing, communication, and payment structure. Putting time and energy into community partnerships is one of the best investments your CMHC can make.

Community Reach Center

Community Reach Center employs nearly 600 mental health professionals who provide counseling services and coordinate therapeutic support groups in a confidential, trauma-informed setting. The center serves consumers of all ages and promotes total mind and body wellness in order to enhance the health of its community.

Community Reach Center partnered with a local Federally Qualified Health Center (FQHC), Salud Family Health Center, to create the Commerce Health Home, which offers services that include physical health, behavioral health, and dental care. In transforming its processes to include primary care services, Community Reach Center incorporated the physical health provider into its weekly staff meetings and "meet the provider" sessions into several behavioral health groups. It also offered a peer-led WHAM group, which is a structured group curriculum focused on healthy living. Guiding the process was insight from the center's transactional analysis (TA) coach on setting small, measurable goals to drive incremental progress toward integration.

During the pilot program, Community Reach Center served 337 consumers, providing approximately 96,000 services. Nearly 45% of those consumers reported an increase of 5 points or more between their first and last interaction. In addition, a significant percentage of consumers reported improvements in Health Related Quality of Life scores.

Ultimately, Community Reach Center concluded that participation in the SIM program was a valuable experience both for staff and consumers.

Jefferson Center

Jefferson Center for Mental Health Services (JCMH) is a nonprofit, community-focused mental health care and substance use services provider. For over 60 years, the organization has offered assistance and provided hope to individuals and families who are struggling with mental health issues and substance use disorders in Jefferson, Gilpin, and Clear Creek Counties. JCMH is an integral part of communities there and provides a variety of programs for people of all ages and from all walks of life.

As part of the Bi-Directional Integration Demonstration and Practice-Based Research Pilot Program, JCMH partnered with a local Federally Qualified Health Center (FQHC), STRIDE Community Health Center, to create the Jefferson Plaza Family Health Home (JPFHH) and offer services that include physical health, behavioral health, wellness coaching and services, care coordination, and dental care among others.

Outcomes measured by JCMH staff include that at one year, 78% of patients increased the number of healthy days they reported having. Patients assessed using the CCAR (Client Assessment Record) showed significant improvement in areas like "Self-Care/Basic Needs" and "Overall Symptom Severity." In addition, there was a downward trend in proportion of total claims that were Emergency Department (ED) visits or Emergency Department Evaluation and Management (EnM ED).

Patient data and feedback indicate that the health home provides a valuable introduction to JCMH and its services.

Mental Health Partners

Mental Health Partners (MHP) traces its history back to 1962, and became a federally designated comprehensive community mental health center in 1971. Today, MHP supports many communities, with locations in Boulder, Broomfield, Longmont and Lafayette. In one recent year alone, MHP provided clinical care to 16,300 clients, served 6,000 in community-based programs and delivered presentations, education or training to 34,500 individuals.

MHP partnered with Clinica Family Health and Dental Aid to form the Boulder Integrated Health Home (IHH). The collaboration is designed to meet the whole-health needs of individuals with serious mental illness and/or addictions and chronic co-occurring physical health conditions. Using the skills of a multidisciplinary team (primary care providers, medical assistants, primary care nurses, dental hygienists, dental case managers, behavioral health providers, etc.), Boulder IHH simplifies the navigation of a complex and often siloed healthcare system by reducing duplication and improving communication with the patient and among their providers for better engagement, satisfaction, and health outcomes.

Some of the many positive results from implementing an integrated approach to care include that 91% of IHH clients reported having a positive perception of care, 63% reported an improvement in daily functioning at reassessment, 58.8% have shown improvement in Hgba1c levels, and 46.7% of clients who began treatment at the IHH with an obese or overweight BMI have shown improvement (i.e. reduced BMI).

Objective results include strong satisfaction with the new approach among staff members and buy-in at all levels of the organizations.

Southeast Health Group

Southeast Health Group (SHG) does challenging work in Southeastern Colorado. The rural and frontier region it serves covers 9,533 square miles with an aggregate population of 46,727. The people there are proud and hardworking, but face problems of few job opportunities, low incomes, low educational attainment, high rates of childhood poverty, and overall poorer health compared to the rest of Colorado. Consequently, patients are more likely suffering from co-occurring behavioral health and physical health ailments.

Already a fully integrated health home, including a community mental health center, primary care clinic, and physical therapy, SHG added another primary care provider pair (mid-level and medical assistant) as part of the Bi-Directional Integration Demonstration and Practice-Based Research Pilot Program. In doing so, they sought to provide patients with complex and dual-diagnosis conditions more time with providers while maintaining the necessary profit margin.

Through participation in this program, the number of shared patients grew from 14 in the first year to 138 at the end of the study, and the third-party collection rate went from 34% to 53.5%. SHG also developed a risk stratification model that was incorporated into workflows and shared with other organizations, enabling leaders to understand the patient population and standardize care across provider types.

Overall, while health outcomes have remained positive thanks to integrated care, reimbursement is an issue that SHG must address.

Additional Resources

Community Mental Health Centers

Community Reach Center, Commerce City, Colorado

https://www.communityreachcenter.org/

Jefferson Plaza Family Health Home – Jefferson Center for Mental Health, Lakewood, Colorado

https://www.jcmh.org/jefferson-plaza-family-health-home/

Mental Health Partners Ryan Wellness Center, Boulder, Colorado

https://www.mhpcolorado.org/about/locations/boulder/integrated-health-home/

Southeast Health Group, La Junta, Colorado

https://www.southeasthealthgroup.org/

Colorado Resources

Colorado Behavioral Healthcare Council

https://www.cbhc.org/

Colorado State Innovation Model (office closed July 31, 2019)

https://www.colorado.gov/healthinnovation

Colorado State Innovation Model (SIM) Framework and Milestones

http://resourcehub.practiceinnovationco.org/wp-content/uploads/2017/11/SIM-Framework-and-Milestones.pdf

Practice Innovation Resource Hub

http://resourcehub.practiceinnovationco.org/

National Resources

National Council for Behavioral Health, Integrated Care

https://www.thenationalcouncil.org/integrated-health-coe/