# Payment and Delivery Innovations in Colorado

## Updated October 2013


CENTER FOR IMPROVING
**VALUE** IN HEALTH CARE

Higher Quality. Lower Cost.
A Healthier Colorado.

# Overview

To inform and advance the Triple Aim goals of improving health, enhancing health care quality, and achieving cost containment, the Center for Improving Value in Health Care (CIVHC) developed this working document identifying payment reform strategies and delivery system redesign initiatives in Colorado that are in various stages of development and implementation.

This information is intended to be a reference as we consider progress made to date and identify opportunities to "connect the dots" toward building an efficient and effective health care system for Colorado.

In addition to the information in this document, CIVHC also monitors ideas that are in the incubation stage (e.g., applications to the Center for Medicare & Medicaid Innovation Challenge that did not receive awards). Our goal is to identify opportunities to "scale up" community-specific responses to challenges that exist statewide, in order to minimize duplication and develop coordinated statewide approaches.

It is important to note that this overview of strategies does not address the results and outcomes of the initiatives described. In many cases, the Colorado programs listed are just launching, and there is no (or insufficient) data to evaluate. Readers are encouraged to refer to the CIVHC/Colorado Health Institute white paper "New Approaches to Paying for Health Care: Implications for Quality Improvement and Cost Containment in Colorado" (available at www.civhc.org) for an overview of the available evidence nationwide regarding the non-fee-for-service payment strategies described below. In future documents, CIVHC will provide assessments of the effectiveness of the interventions listed here.

NOTE: The overviews below are based on information provided by the participants themselves. While the following inventory captures a number of health care payment reform and delivery system redesign initiatives underway in Colorado, this is a working document that may not yet include all efforts in progress. Please contact info@civhc.org for more information and to request additions/updates to future versions.

# Users Guide

The inventory is presented in two tables, one for Payment Reform strategies and one for Delivery System Redesign initiatives. Programs are categorized based on the type and number of interventions the program utilizes from fewest to most. For example, payment initiatives utilizing one non-fee-for-service payment approach such as shared savings are listed at the top of the table, whereas initiatives employing multiple approaches such as shared savings, care coordination, and pay-for-performance will be further down the table. Programs using similar approaches are categorized together to provide the user with a quick visual crosswalk of like programs. A table of contents is also available by organization lead (if applicable) and project name so users can quickly identify a particular program of interest.

The following table identifies the key strategies included in the inventory tables.

| Payment Reform Strategies | Delivery System Redesign Strategies |
|---|---|
| • Care for Coordination Payments | • Integration of Physical & Behavioral Health |
| • Bundled Payments | • Care Transitions |
| • Pay for Performance | • Patient Centered Medical Home |
| • Shared Savings | • Patient Navigation |
| • Global Payments | • Shared Decision Making |
| • Salaried Physicians | • Self-Management, Coaching, Patient Engagement |
| | • Minimizing Unwarranted Variation |
| | • Health Information Technology/Health Information Exchange |

Key definitions for both payment reform and delivery system redesign and a list of acronyms are included to provide the user with an overview of the terminology most commonly used throughout this document.

***Please visit www.civhc.org for additional resources including:***

- New Approaches to Paying for Health Care: Implications for Quality Improvement and Cost Containment in Colorado (CIVHC/CHI white paper, July 2012)
- Framework for Transforming the Health Care Payment System in Colorado (CIVHC, July 2011)
- Vocabulary of Health Care Reform White Paper (Thomson Reuters, April 2012)

# Key Definitions

Bibliographies for the definitions below can be found in "New Approaches to Paying for Health Care: Implications for Quality Improvement and Cost Containment in Colorado" and "Key Payment and Delivery System Definitions" at www.civhc.org.

| Payment Terms | Delivery System Terms |
|---|---|
| • Fee-for-Service | • Accountable Care Organization |
| • Pay For Performance | • Inpatient Care |
| • Care Coordination Payments | • Specialty Care |
| • Gain Sharing and Shared Savings | • Outpatient Care |
| • Bundled Payment | • Medical Home |
| • Global Payment | • Chronic Care |
| | • Primary Care |
| | • Acute Care |
| | • Care Management |

## *Payment Terms*

- **Fee-for-service payment (FFS)**. Under FFS, providers are paid a predetermined amount for each discrete service. They bill using a long-standing coding system that categorizes each service, whether a blood test, checkup or open heart surgery, according to narrowly prescribed parameters. Providers submit itemized claims to commercial insurers and public payers detailing the services provided during an encounter and tie them to billing codes. Providers are paid for in-person encounters but not for phone or email consultations or other work that does not have a billing code. The quality of care or its outcome for the patient does not make a difference in how much the provider is paid.
- **Pay for performance (P4P)**. Pay for performance rewards providers for meeting or exceeding pre-established benchmarks for care processes and patient health outcomes. For example, a pediatrician may receive a bonus if a majority of patients receive recommended immunizations. Similarly, hospitals that score well on quality-of-care measures such as surgical complications or mortality may receive rewards.
- **Care coordination payments.** In the care coordination payments model, health care providers receive monthly payments (in addition to their standard FFS reimbursements) to pay for the infrastructure needed to enable care coordination — costs that are not reimbursable under the FFS model. Examples include health information technologies such as electronic medical records and disease registries to help providers track and manage patients' care, and additional staff including nurses, medical assistants and other professionals. These staff may provide a range of care coordination and patient support services, including following up with patients between visits, staffing 24/7 patient call lines, providing education and self-care techniques, and serving as a communications hub among a patient's health care providers.

  Care coordination payments are most often found in the context of medical homes. Medical homes are delivery innovations designed to improve the continuity of care in the primary care setting, and to improve coordination

among primary care providers and specialists, oral health and behavioral health providers, hospitals and long term services and supports providers.

- **Gain sharing and shared savings.** This model offers providers a percentage of net savings resulting from their efforts to reduce health spending for a defined population. Alternatively, providers may earn bonuses for keeping costs below established benchmarks. Gain-sharing and shared savings models may be used by individual providers or small group practices as well as larger networks of providers.

  Under a hypothetical shared savings arrangement, a provider who reduces the average annual total health care costs for her patients below a target, based on the previous expense of those patients and anticipated costs based on the patients' demographics and risk factors, may be eligible to receive a percentage of savings.

- **Bundled payment.** Bundled payment is a model that provides a single payment to a provider, or a group of providers, for all health care services associated with a defined episode of care. The episode may be for a specific condition (diabetes, for example), event (heart attack) or medical procedure (hip replacement). Most episodes of care have a reasonably well-defined beginning and end, but for management of chronic conditions, episodes are defined as all of the condition-related services in a certain period of time (for example, 12 months). Payment bundles can be adjusted to reflect the risk or severity of patients' conditions. The goal of bundled payment is to control costs and improve outcomes by reducing or eliminating unnecessary or inefficient care and spending, and giving providers an incentive to work together to accomplish these goals.

  For example, a bundled payment for joint replacement would cover a defined span of time (from hospital admission through a certain number of weeks of rehabilitation after the patient leaves the hospital) and a defined array of providers and services (surgeon, anesthesia team, rehab team, all hospital services and rehab care within the timeframe). Quality expectations and benchmarks are built into the bundle. For example, if the patient must be readmitted to the hospital for a potentially avoidable complication, the hospital/ clinicians must cover that cost.

  Savings are shared with providers when total expenditures for the episode of care are less than they would have been under FFS. This is intended to provide incentives for providers participating in the bundle to work together to identify potential up-front cost savings such as negotiating lower prices for surgical supplies and devices like implants. It is also designed to provide an incentive for providers to coordinate with one another in ways that they may not have previously. For example, the surgeons in a bundled arrangement may decide they need to check on their patient's progress at the rehab facility on a regular basis, something they receive no payment or incentive to do under the FFS model.

- **Global payment**. Under global payment, providers are prospectively compensated for all or most of the care that their patients may require over a contract period, such as a month or a year. This is sometimes referred to as population-based payments, risk-based capitation or comprehensive care payments. Bundled payments made for chronic conditions such as diabetes can also be thought of as disease-specific global payments. Like bundles, global payments are adjusted to reflect the health status of the patient. This risk adjustment protects providers from potentially significant financial losses associated with caring for patients with higher than average health care costs.

  Global payment differs from the capitated payment model under managed care in the 1990s in some important ways. Although, like old-school capitation, global payment represents a fixed dollar payment per patient to a provider for care, it includes incentives, such as quality bonuses, to discourage under-treatment and to maintain or improve patient access to services. In addition, the data management systems available to health care providers today are better suited to the information challenges associated with global payment. Recent pilot programs have provided technical assistance to participants to help address associated data and information management challenges.

  Global payment provides financial incentives to deliver coordinated, efficient care and to promote preventive and health maintenance activities among patients because providers bear at least some financial risk for the cost and outcomes of patient care. Under a full risk model, providers retain any savings when the total cost of care is below the global payment amount. They are also responsible for paying any cost overages. Under a shared risk model, the provider and payer share any retained savings as well as take joint responsibility for paying costs above the budgeted amounts.

## *Delivery System Terms*

- **Medical home (also known as health care home, primary care medical home, patient-centered medical home and advanced primary care).** A model of enhanced primary care, centered around the patient's needs and characterized by each patient having a personal provider responsible for coordinating and providing or arranging for all of his/her care; care coordination across all settings and practitioners by a provider-led team of health care professionals; expanded health care access for patients (e.g., after-hours care); evidence-based care; collaborative patient involvement in all care decisions, with adequate information provided to patients to support decision making; an emphasis on quality and safety; and provider-specific assessments of care efficiency and quality.
- **Accountable Care Organization (ACO).** A local, provider-led entity comprised of a wide range of collaborating providers. ACOs monitor, manage and coordinate acute and chronic care across multiple or all care settings (e.g., physician practices, clinics, outpatient settings and hospitals) and are accountable to health care payers (e.g., Medicaid, Medicare or private insurers) for the overall cost and quality of care for a defined population. An ACO can be an independent nonprofit organization formed specifically to serve as an ACO, an independent practice association, a multi-specialty group, a hospital-medical staff organization, a physician-hospital organization or a fully integrated health care delivery system. Providers in an ACO share some financial risk for meeting or exceeding performance goals across all providers and patients and may earn less if benchmark goals are not met.
- **Chronic care.** Care for a condition that has lasted or is expected to last twelve or more months and has resulted in functional limitations and/or the need for ongoing medical care.
- **Inpatient care.** Care for services delivered to a patient who needs physician care for > 24 hours in a hospital.
- **Primary care.** Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings. Primary care is performed and managed by a provider often coordinating with other health professionals, and utilizing consultation or referral as appropriate. Basic or general health care traditionally provided by doctors trained in: family practice, pediatrics, internal medicine, and occasionally gynecology.
- **Specialty care.** Specialized consultative care, usually on referral from primary or secondary medical care personnel, by physicians whose training focused primarily in a specific field, such as neurology, cardiology, rheumatology, dermatology, oncology, orthopedics, ophthalmology, and other specialized fields.
- **Acute care**. Short-term treatment for a severe injury or episode of illness and the opposite of chronic care. It entails stay in a short term facility such as a hospital.
- **Outpatient care**. Care that does not require an overnight stay or hospitalization. It may be performed in a clinic, medical office, ambulatory surgery center, hospital or any other number of facilities.
- **Care management**. Coordination of care in order to reduce fragmentation and unnecessary use of services, prevent avoidable conditions, and promote independence and self-care. This is sometimes used interchangeably with case management. Others differentiate the two terms. *Care management* can refer to a global approach to medical care from prevention through treatment and recovery while *case management* can refer to coordination of services to help meet a patient's health care needs, usually when the patient has a condition which requires multiple services from multiple providers.

# Inventory Table of Contents (alpha. order)

# Colorado Payment Reform Strategies

The following table summarizes initiatives (active or proposed) designed to test new ways of delivering health care to improve quality and control costs in CO.

## ACRONYM GUIDE

| | | | | | |
|---|---|---|---|---|---|
| ACA | Affordable Care Act | CMS | Centers for Medicare & Medicaid Services | PCP | Primary Care Provider |
| ACC | Accountable Care Collaborative | FFS | Fee for Service | PCMH | Patient Centered Medical Home |
| ACO | Accountable Care Organization | FQHC | Federally Qualified Health Center | PMPM | Per Member Per Month payment |
| HCPF | CO Dept. of Health Care Policy and Financing | HIE | Health Information Exchange | RCCO | Regional Care Collaborative Organization |
| CHP+ | Child Health Plan Plus | HIT | Health Information Technology | RHC | Rural Health Clinic |
| CMMI | Center for Medicare & Medicaid Innovation | P4P | Pay for Performance | | |

## Non-FFS PAYMENT STRATEGIES IN COLORADO

| Lead Org/*Title* | SUMMARY | Population | Care Coordination Payments | Bundled Payments | Pay for Performance | Shared Savings | Global Payments | Salaried Physicians |
|---|---|---|---|---|---|---|---|---|
| **Colorado Children's Healthcare Access Program** | Medical home program for children in Medicaid and CHP+; provides enhanced reimbursement to pediatricians; launched in 2007, now includes 95% of private practice pediatricians statewide as well as safety net providers. Program overseen by nonprofit, funded by Colorado foundations. | Medicaid Kids | ■ | | | | | |
| **HCPF/Medicaid** *Accountable Care Collaborative* | Modified managed care pilot within the Medicaid program. The ACC divides the state into 7 RCCOs, which affiliate with local primary care providers. Those providers receive traditional fee-for-service payments with care coordination payment supplements to support care coordination for their ACC patients. | Medicaid | ■ | | | | | |
| **HCPF/Medicaid** *Person centered payments in long term care, health homes* | Creates long term care health homes within the ACC (launch in 2013). Redesign the care planning tool and assessment form for community-based long term care services. | Medicaid | ■ | | | | | |
| **CMMI** *Comprehensive Primary Care Initiative* | PCMH initiative combining care coordination payments from Medicare with those from private payers for up to 100 primary care practices. Also includes potential for shared savings. Four-year pilot, launching late summer 2012. The 9 Colorado payers: Anthem, CIGNA, Colorado Access, Colorado Choice Health Plans, CO Medicaid, Humana, Rocky Mountain Health Plans, Teamsters Multi-Employer Taft Hartley Funds, UnitedHealthcare | Medicare, Commercial | ■ | | | ■ | | |
| **Colorado Access** | A nonprofit health plan that provides behavioral and physical health services for Colorado residents on Medicare/Medicaid, and provides administrative services for CHP+ State Managed Care Network and CHP+ Prenatal Program. | Medicaid | ■ | | | ■ | | |

# Non-FFS PAYMENT STRATEGIES IN COLORADO

| Lead Org/*Title* | SUMMARY | Population | Care Coordination Payments | Bundled Payments | Pay for Performance | Shared Savings | Global Payments | Salaried Physicians |
|---|---|---|---|---|---|---|---|---|
| **HCPF/Medicaid**<br>*Physician Rate Reform and Gain-sharing* | The ACA requires an increase in physician rates to 100% of Medicare for 2013 and 2014. Medicaid is working with CMS to allow for innovative ways to use the incentive rather than across the board FFS increase, and contingent upon their approval will design an incentive pool and supplemental payment program. | Medicaid | ■ | | | ■ | | |
| **Colorado Choice Health Plans/San Luis Valley HMO** | A Colorado based non-profit health plan involved in several pilots including a bundled episode of care payment pilot (Prometheus) covering asthma, diabetes and heart disease. Other pilots include the Innovative Benefit Design Pilot, with Engaged Public, focusing on shared decision making, self-management and patient engagement and the Comprehensive Primary Care Initiative (CPCI) with CMMI, focusing on patient centered medical homes. | Medicare, CHP+, Commercial | ■ | ■ | | ■ | | |
| **Aetna**<br>*Patient Centered Medical Home* | Program broadens access of patients to primary care while enhancing care coordination. Payment methodology recognizes added value provided to patients with a medical home. Efficiency measures drive savings which the provider group shares. | Commercial | ■ | | ■ | ■ | | |
| **Anthem**<br>*Patient Centered Primary Care Program* | New program that will fundamentally change relationship with PCPs by increasing company investment in their practices and health of their patients. Increase revenue opportunities for participating PCPs, enhance info sharing, and provide care management support for clinical staff. Builds off of Colorado multi-payer PCMH pilot; will eventually supersede previous pay-for-performance program for PCPs. | Commercial | ■ | | ■ | ■ | | |
| **Cigna**<br>*Collaborative Accountable Care* | Built on the foundation of the PCMH and ACO concepts with outcomes-based reward for quality and value. Includes information-sharing, integration of services and incentive based payment. Key component: Embedded care coordinators for patient centered care delivery. | Commercial | ■ | | ■ | ■ | | |
| **United Healthcare** | For commercial members, clinical integration fees (care coordination). Value based contracts tying payment to quality and cost benchmarks. May include bonuses, gain-share, tying contract escalators to performance metrics. For Medicare members, advanced generation population-based reimbursement methodologies including partial and global capitation and shared savings. | Commercial, Medicare | ■ Commercial only | | ■ Commercial only | ■ | ■ Medicare only | |
| **Rocky Mountain Health Plans**<br>*SHAPE Demo* | Comprehensive Care Payment Reform: Population-based reimbursement methodologies including accountability for total cost of care for patients through partial and global capitation and bonus opportunity for measured quality independent of global budget targets. | Medicare, Medicaid, Commercial | ■ | | ■ | ■ | ■ | |

# Non-FFS PAYMENT STRATEGIES IN COLORADO

| Lead Org/*Title* | SUMMARY | Population | Care Coordination Payments | Bundled Payments | Pay for Performance | Shared Savings | Global Payments | Salaried Physicians |
|---|---|---|---|---|---|---|---|---|
| **Humana** | Working on a number of different payment reform strategies, including current participation for care coordination, and pursuing bundled payments in several specialty categories. For Medicare only, looking at P4P, shared savings, and global payments. | Commercial, Medicare | | | Medicare only | Medicare only | Medicare only | |
| **Rocky Mountain Health Plans** *1281 Medicaid Pilot Project* | The two year pilot program will focus on payments for services delivered to clients in Delta, Garfield, Gunnison, Mesa, Montrose, Pitkin, and Rio Blanco counties. The pilot program includes behavioral health integration, global payments, and risk and gain-sharing arrangements which will allow payments to providers for value at the point of care. These payments will be designed to ensure reimbursement to give providers the time and capacity needed to perform the activities required for whole person care, accountability for the total cost of care, and bonus opportunities for quality improvement. The proposal is sponsored by Rocky Mountain Health Plans, Colorado West Regional Mental Health Center, Midwestern Colorado Mental Health Center, along with multiple independent physician groups, hospital and health systems, Federal Qualified Health Centers, primary care providers, and public health and human services agencies. | Medicaid | | | | | | |
| **Denver Health** *MedicaidChoice* | Denver Health's salaried clinicians serve Medicaid patients through 2 avenues with differing payment structures: Its Medicaid Choice program provides comprehensive, risk adjusted payment via a capitated PMPM for primary care, specialty care, pharmacy, durable medical equipment, home health care, and hospital services. This system may be referred to as a community integrated health care system or an advanced accountable care organization. Denver Health also participates in the ACC, and pays its providers through different mechanisms for that program. | Medicaid | Medicaid ACC | | | Medicaid ACC | Medicaid Choice | Medicaid Choice/ACC |
| **CMS** *Acute Care Episode Demonstration Exempla St. Joseph's* | In Colorado, Exempla St. Joseph's Hospital is participating in this bundled payment pilot for inpatient cardiac services. | Medicare | | | | | | |
| **Colorado Business Group on Health** *Health Incentives Payment Pilot/PROMETHEUS* | Episode of care/bundled payment pilot in Boulder, Colorado Springs and Alamosa (in Alamosa through CO Choice Health Plans/SLV HMO). Pilot covers 6 chronic conditions: asthma, chronic obstructive pulmonary disease, coronary artery disease, diabetes, gastroesophageal reflux disease and hypertension. Funded by the Colorado Health Foundation through a grant to the Health Care Incentives Improvement Institute; administered by the Colorado Business Group on Health. | Commercial | | | | | | |

# Non-FFS PAYMENT STRATEGIES IN COLORADO

| Lead Org/*Title* | SUMMARY | Population | Care Coordination Payments | Bundled Payments | Pay for Performance | Shared Savings | Global Payments | Salaried Physicians |
|---|---|---|---|---|---|---|---|---|
| **CMMI**<br>*Bundled Payments for Care Improvement* | Pilot testing 4 different models of bundled payments to hospitals. The program launched in January. The Colorado hospitals that have received awards are: University of Colorado Hospital and Penrose/St. Francis for Chronic Heart Failure and Coronary Artery Bypass grafting; Exempla Good Samaritan and Exempla St. Joseph's for joint replacement. | Medicare | | ■ | | ■ | | |
| **Colorado Business Group on Health**<br>Bridges to Excellence | Pay-for-performance program developed by the Health Care Incentives Improvement Institute and administered locally by the Colorado Business Group on Health. Provides bonus payments to physicians who meet national standards for screening and effectively managing the care of patients with diabetes or cardiac disease. | Commercial | | | ■ | | | |
| **HCPF/Medicaid**<br>*Payment Reform Pilots* | HB12-1281 establishes a process to test new payment approaches within the ACC in 2013-2014. | Medicaid | | | ■ | ■ | ■ | |
| **HCPF/Medicaid**<br>*Accountable Care Collaborative Gain-share* | Gain-sharing payment to RCCOs and primary care providers for portion of additional savings attributed to ACC program. ACC is budgeted to save 7% per client in total expenditure, any portion savings above would be shared with the providers. Program launches Jan. 2013. | Medicaid | | | | ■ | | |
| **HCPF/Medicaid**<br>*FQHC/RHC Gain-share* | Supplemental payment to FQHCs/RHCs that demonstrate efficiencies and contribute to savings in services provided to their clients. Providers keep 50% of measured savings. Program launches 2013. | Medicaid | | | | ■ | | |
| **HCPF/Medicaid**<br>*Psychotropic Med Use Gain-share* | Beginning in 2014, Medicaid will share savings from prescription savings with behavioral health organizations (the entities that manage Medicaid behavioral health benefit). | Medicaid | | | | ■ | | |
| **Centura**<br>*Colorado Accountable Care* | This ACO launched in January 2013 and is in the process of implementation. The initiative is only offered in Centura facilities by Centura employees for now, but expansion outside the company is possible. The initiative focuses on shared savings determined though 33 quality measures with information gathered from a patient registry and EHRs. | Medicare-eligible Centura patients | | | | ■ | | |
| **Physician Health Partners**<br>*Medicare Shared Savings Program* | Five-year pilot will hold primary care practices accountable for the cost and quality of care delivered to their Medicare patients. In the first 2 years, practices will share savings with Medicare; as their ability to manage risk matures and they meet savings and quality benchmarks, practices will transition to global payments with the potential for shared losses as well. Supported through CMMI. | Medicare | | | | ■ | ■ | |

| Non-FFS PAYMENT STRATEGIES IN COLORADO | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Lead Org/*Title*** | **SUMMARY** | **Population** | **Care Coordination Payments** | **Bundled Payments** | **Pay for Performance** | **Shared Savings** | **Global Payments** | **Salaried Physicians** |
| **Kaiser Permanente**<br>*COMPASS* | The Kaiser Permanente Health Plan contracts with the Colorado Permanente Medical Group, which in turn negotiates contract terms with its member physicians. Physicians within Kaiser's HMO are paid on salary; those in its looser network model are paid through other mechanisms as negotiated between the physicians and the Medical Group. | Commercial, Medicaid | | | | | | Staff Model HMO |

# Colorado Delivery System Redesign Strategies

The following table summarizes initiatives currently underway or about to launch in Colorado that are designed to test new ways of delivering health care to improve quality and control costs.

## ACRONYM GUIDE

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| HCPF | CO Dept. of Health Care Policy and Financing | HIE | Health Information Exchange | RCCO | Regional Care Collaborative Organization |
| CHP+ | Child Health Plan Plus | HIT | Health Information Technology | RHC | Rural Health Clinic |
| CMMI | Center for Medicare & Medicaid Innovation | P4P | Pay for Performance | | |

## COLORADO DELIVERY SYSTEM REDESIGN STRATEGIES

| Lead Org/ *Title* | SUMMARY | Population | Integrate Physical & Behavioral | Care Transitions, Readmissions | Patient Centered Medical Home | Patient Navigation | Shared Decision Making | Self-Management, Coaching, Patient Engagement | Minimize Unwarranted Variation | HIT/HIE |
|---|---|---|---|---|---|---|---|---|---|---|
| **Colorado Department of Human Services & CU Health Sciences Center** *Project Bloom* | Focuses on young children from birth through 5 years old with serious emotional disturbances. Provide enhanced training, integrated delivery of services, statewide working groups focusing on system improvements and sustainable resources for addressing children's mental health. Partners include early childhood leaders/educators, mental health centers, departments of human services, employment and training programs, and others. Funded by the federal Substance Abuse and Mental Health Services Administration, Temple Hoyne Buell Foundation, and Colorado Dept. of Human Services Division of Behavioral Health. | Medicaid ages birth-5 | ■ | | | | | | | |
| **Rocky Mountain Health Plans** *SHAPE Demo* | Accountable Care Community: Delivery system transformation incorporating advanced use of health information technology and integrating physical and behavioral health. Strategy covers all lines of business (Medicare, Medicaid, commercial) while prioritizing efforts around those <250% FPL and also accounting for the uninsured. | Medicare, Medicaid, and Commercially Insured Clients | ■ | | | | | | | |

| COLORADO DELIVERY SYSTEM REDESIGN STRATEGIES | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Lead Org/ *Title*** | **SUMMARY** | **Population** | **Integrate Physical & Behavioral** | **Care Transitions, Readmissions** | **Patient Centered Medical Home** | **Patient Navigation** | **Shared Decision Making** | **Self-Management, Coaching, Patient Engagement** | **Minimize Unwarranted Variation** | **HIT/HIE** |
| **University of Colorado** *Advancing Care Together (ACT)* | The Department of Family Medicine at the University of Colorado is leading an initiative to integrate physical/behavioral health for patients with chronic conditions and emotional/behavioral problems. Partners with 11 clinical sites in urban and rural areas, including FQHCs, community mental health centers, large and small primary care practices. | Individuals with emotional and behavioral problems | | | | | | | | |
| **Colorado Behavioral Healthcare Council** *Colorado Psychiatric Access and Consultation for Kids (C-PACK)* | A grant from the Colorado Health Foundation will expand and improve access to behavioral health care and strengthen partnerships between health care providers. C-PACK will assist primary care providers through child psychiatry consultation teams statewide. The program includes many collaborators, including: CBHC, the REACH Institute, ValueOptions, Colorado Access, Colorado Children's Health Access Program, the Colorado Chapter of the Academy of American Pediatrics, ClinicNet, and Colorado Community Health Networks. The program may reach over 300,000 Colorado children in need of integrated behavioral and physical care. | Children in Denver Metro and Southern Colorado in need of psychiatric care | | | | | | | | |

| COLORADO DELIVERY SYSTEM REDESIGN STRATEGIES | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Lead Org/ *Title*** | **SUMMARY** | **Population** | **Integrate Physical & Behavioral** | **Care Transitions, Readmissions** | **Patient Centered Medical Home** | **Patient Navigation** | **Shared Decision Making** | **Self-Management, Coaching, Patient Engagement** | **Minimize Unwarranted Variation** | **HIT/HIE** |
| **Rocky Mountain Health Plans** *1281 Medicaid Pilot Project* | The two year pilot program will focus on payments for services delivered to clients in Delta, Garfield, Gunnison, Mesa, Montrose, Pitkin, and Rio Blanco counties. The pilot program includes behavioral health integration, global payments, and risk and gain-sharing arrangements which will allow payments to providers for value at the point of care. These payments will be designed to ensure reimbursement to give providers the time and capacity needed to perform the activities required for whole person care, accountability for the total cost of care, and bonus opportunities for quality improvement. The proposal is sponsored by Rocky Mountain Health Plans, Colorado West Regional Mental Health Center, Midwestern Colorado Mental Health Center, along with multiple independent physician groups, hospital and health systems, Federal Qualified Health Centers, primary care providers, and public health and human services agencies. | Medicaid | | | | | | | | |
| **Kaiser Permanente in Colorado (CO lead)** *Care management of mental and physical co-morbidities: a Triple Aim bull's-eye* | Improve care delivery/outcomes for high risk adults with depression and diabetes or cardiovascular disease by using care managers and health care teams to assess condition severity, monitory care through computerized registry, provide relapse/exacerbation prevention, intensify/change treatment as needed, and transition patients to self-management. Multistate initiative funded through CMMI's Innovation Challenge to the Institute for Clinical Systems Improvement. | High risk adults with depression /diabetes or cardiovasc. disease on Medicare and/or Medicaid | | | | | | | | |

| COLORADO DELIVERY SYSTEM REDESIGN STRATEGIES | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Lead Org/ *Title*** | **SUMMARY** | **Population** | **Integrate Physical & Behavioral** | **Care Transitions, Readmissions** | **Patient Centered Medical Home** | **Patient Navigation** | **Shared Decision Making** | **Self-Management, Coaching, Patient Engagement** | **Minimize Unwarranted Variation** | **HIT/HIE** |
| **Mental Health Center of Denver** *Promoting Resources for Integrated Care and Recovery Plus (PRICARe Plus)* | The Mental Health Center of Denver will partner with Denver Health, University of Colorado Denver's Department of Family Medicine, and Colorado Access to develop the Promoting Resources for Integrated Care and Recovery Plus (PRICARe Plus) program. PRICARe Plus will provide primary care services through a family physician supervised Denver Health nurse practitioner at the Mental Health Center of Denver. The project began in 2009 and is set to continue through 2013. PRICARe Plus received a SAHSA/HRSA Primary Care and Behavioral Health Integration Grant. | Individuals with emotional and behavioral problems | ■ | | | | | ■ | | |
| **Metropolitan Community Provider Network** *Sustainable High Utilization Team Model* | Expands/tests team based care management for high cost/need low income populations. Care management teams provide clients with support to address health care needs and social needs including finding housing/shelter, applying for coverage/disability benefits, handling legal issues, finding transportation, treating depression, managing chronic illness, coordinating specialty care and transition to local PCMH. Colorado partners include Aurora Mental Health, Together Colorado, and Aurora Health Access. Multistate initiative funded to Rutgers, the State University of New Jersey through CMMI's Innovation Challenge. | High cost, high need, low income | ■ | ■ | | | | ■ | | |

| COLORADO DELIVERY SYSTEM REDESIGN STRATEGIES | | | | | | | | | | |
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| **Jefferson Center for Mental Health** *Union Square Health Home* | Jefferson Center for Mental Health (Jefferson Center), a community mental health center, intends to establish the Union Square Health Home (USHH) at its new outpatient office. The Union Square Health Home, a partnership approach that builds on the history of healthcare integration between Jefferson Center; Metro Community Provider Network (MCPN), a federally qualified health center; and Arapahoe House (AH), a publicly-supported, non-profit substance abuse treatment provider. Besides housing Jefferson Center outpatient and wellness services, Union Square will house a 10 exam room, primary care medical office for MCPN and an AH Clinical Specialist who is available to provide enhanced substance abuse assessments and interventions. Specific strategies include: formal partnership agreements with MCPN and A H to provide collaborative care for patients with acute health needs; comprehensive care management and monitoring of treatment adherence through a Health Home Care Coordinator; bi-weekly collaborative care management meetings involving health care providers from the 3 organizations; creation of person-centered comprehensive care plans incorporating physical, behavioral, and wellness health goals; routine physical health screenings; implementation of a shared electronic Patient Registry; benefits enrollment support for clients; and an array of personalized and group health and wellness services. USHH plans to serve a minimum of 200 clients within the first year and grow to a minimum of 600 clients at the end of 4 years. The primary measurable objectives to achieve are that 70% of clients will have a PCP and have received an annual physical and that 60% of patients identified with a potential substance abuse issue will receive appropriate assessment and treatment. | Patients with behavioral and acute physical health needs | | | | | | | | |

| COLORADO DELIVERY SYSTEM REDESIGN STRATEGIES | | | | | | | | | | |
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| **Aurora Mental Health Center (AuMHC)** *Health Home* | AuMHC proposes to serve its over 8,000 adult patients with serious mental illness (SMI), with additional outreach efforts to serve the Aurora refugee population with serious mental illness. Almost half are below the federal poverty level and receive public insurance. Thirty-nine percent of adults with SMI at AuMHC have diagnosed chronic diseases including hypertension, diabetes, asthma, arthritis, and hypercholesterolemia. Many refugees in Aurora have high unmet physical and mental health needs and AuMHC will be utilizing its expertise with this population to serve them in the Health Home. AuMHC will be providing quality primary care services by partnering with Metro Community Provider Network (MCPN), an FQHC. The Health Home team will consist of a primary care provider, medical assistant, financial screener, wellness coordinator, health navigator, referral coordinator, consulting psychiatrist, registered nurse, and peer health advocates. Together, the Health Home team will provide patients and their families with a positive health care experience under the evidence-based Chronic Care Model. Based on the proposed population's size, it is expected that the Health Home will serve over 1,000 patients by the end of the grant fund. | Aurora refugee population with serious mental illness | | | | | | | | |
| **Southeast Mental Health Services** *Tipping Point: Total Integration, Patient Navigation and Provider Training* | Coordinate comprehensive, community-based care for high-risk, high-cost, and chronically ill Medicare/Medicaid/CHP+ beneficiaries in Prowers County, Colorado. Train and employ patient navigators to increase access to primary/behavioral care, preventive care, and early intervention services. Team-based education/coaching for disease self-management. Funded through CMMI's Innovation Challenge. Partners include: Otero Junior College, High Plains Community Health Center, Prowers Medical Center, Prowers County Public Health & Environment. | High-risk, chronically ill Medicare and Medicaid and CHP+ in Prowers County | | | | | | | | |

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| **Aspen Pointe Health Services** *Integrated Care Program* | Aspen Pointe Health Services and FQHC Peak Vista are collaborating on the Integrated Care Program. The program has received a SAHSA/HRSA Primary Care and Behavioral Health Integration Grant which will allow it to expand beyond its current operation. Services that patients will receive in the expanded program include: physical health care services and management, care coordination, disease management services, transitional care, support for patients and families, and links to support services and specialty health care. The project began in 2012 and is expected to run through 2016. | Patients at FQHC Peak Vista | ■ | ■ | ■ | ■ | | ■ | | |
| **Denver Health** *21st Century Care* | Multidisciplinary medical home teams including patient navigators, nurse care coordinators and integrated physical/behavioral health care provision, with participation from public health department and access to Denver Health's nurse advice line. Three new high-risk teams for those with multiple hospitalizations and other special needs. Risk-stratified care management to individualize the medical home experience. Health information technology enhancements, including info at point of care and patient communications (reminders, bi-directional text messaging). Funded through CMMI's Innovation Challenge. Partners include: Mental Health Corporation of Denver and partners within already integrated delivery system (hospitals, FQHCs, etc.) | Denver Health patients with advanced care needs, receiving Medicare and / or Medicaid, CHP+, and uninsured | ■ | ■ | ■ | ■ | | ■ | | ■ |
| **Colorado Center for Nursing Excellence** *Home Healthcare Collaborative (HHC)* | Aims to improve transitions of care by building clinical and leadership competencies around home health nursing, implementing system level quality and patient safety improvements, and informing health policy. HHC is a quality initiative focusing on increasing effective communication with all parts of healthcare delivery system, and recommends the use of checklists as a best practice. Funded by the Robert Wood Johnson Foundation, with matching funds from the Colorado Trust, Caring for Colorado, and the Colorado Health Foundation. | All Payers | | ■ | | | | | | |

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| **Christian Living Communities** *South Denver Care Continuum (SDCC)* | Provider roundtable discussions on impact of ACA and elements related to Medicare beneficiaries and providers. Core group includes: skilled nursing facilities, hospitals, home health, home care services, hospice. Focus on 3 areas: care transitions and communication between providers, communication with and wellness of beneficiaries. Has submitted application for the CMS Community Based Care Transition Program. | Medicare | | | | | | | | |
| **Colorado Health Care Association** *Long Term Care Quality Initiative* | Builds upon existing work in long term and post-acute care. Sets measurable, specific targets to improve quality of care in skilled nursing centers and assisted living. Participants reach defined concrete goals related to safely reducing hospital readmissions, increasing staff stability, increasing customer satisfaction, and safely reducing off label use of antipsychotics. | Medicare | | | | | | | | |
| **Colorado Health Care Association** *Reducing Hospitalization and Emergency Department Visits* | Skilled nursing facilities and hospitals using INTERACT: Interventions to Reduce Acute Care Transfers for residents in skilled nursing facilities. | Medicare | | | | | | | | |
| **Colorado Rural Health Center** *Improving Communication and Readmission (iCARE)* | Colorado's rural Critical Access Hospitals focus on improving communication in transitions of care, maintaining low readmission rates, and improving clinical processes contributing to readmissions (e.g. heart failure and pneumonia patients). Funded by the Health Resources and Services Administration's Medicare Rural Hospital Flexibility Grant. | High-utilizer, heart failure patients, pneumonia patients, others as identified by hospital | | | | | | | | |

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| **University of Colorado Denver** *Family Caregiver Protocol* | A family caregiver protocol to reduce hospital readmissions. Grant funding will support development and testing of family caregiver protocol enhancement for the Care Transitions Intervention (see CU School of Medicine program below for explanation). Family caregivers will be trained in the new protocol with the goal of reducing avoidable hospital readmissions for older, chronically ill patients. | Medicare | | | | | | | | |
| **Upper Arkansas Area Council of Governments** *Care Transitions Intervention* | Upper Arkansas Area Council of Governments, an Area Agency on Aging located in Canon City, Colorado, will lead an expansive partnership delivering the Care Transitions Intervention to Medicare beneficiaries in El Paso, Pueblo, Fremont, Chaffee, Custer, Lake, and Teller counties. Many of these beneficiaries reside in medically-underserved and rural areas, and small communities. Providers across the care continuum include acute care hospitals (Centura Health-Penrose St. Francis Health Services, Memorial Hospital Central, Centura Health – St. Mary Corwin Medical Center, Parkview Medical Center and Centura Health - St. Thomas More Hospital), critical access hospitals (St. Vincent Hospital General District, Pikes Peak Regional Hospital, and Heart of the Rockies Regional Medical Center), a Federally-Qualified Health Center (Peak Vista Community Health Center) along with the Pueblo Area Agency on Aging and Pikes Peak Area Council of Governments Area Agency on Aging. | Medicare | | | | | | | | |

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| **HCPF/Medicaid** *Accountable Care Collaborative, Regional Care Collaborative Organizations* | A Colorado Medicaid pilot program to improve health and reduce costs. The components of the ACC program include: Regional Care Collaborative Organizations (RCCOs), primary care medical providers (PCMPs), and the Statewide Data and Analytics Contractor (SDAC). The state is divided into 7 regions, each having a RCCO responsible for achieving financial and health outcomes, and care coordination with a medical home level of care. The PCMP serves as patient centered medical home that promotes self-management. SDAC is responsible for conducting data analytics/reporting and being the data repository/web portal for access. | Adult and Pediatric Medicaid clients | | ■ | ■ | | | | | |
| **Colorado Community Health Network** *FQHC Advanced Primary Care Practice Demonstration* | Will show how the PCMH model can improve quality of care, promote better health, and lower costs. One lead primary care association in each region will partner with others/sites in the demonstration. There will be a Medical Home Facilitator who will provide training and technical assistance to clinics on practice redesign topics such as enhanced access, patient centeredness, and care coordination. Sponsored by the National Association for Community Health Centers, | All patients seen at the partner sites | | ■ | ■ | | | | | |
| **University of Colorado, School of Medicine** *Care Transitions Intervention (CTI)* | CTI was designed in response to the need for a patient-centered, interdisciplinary intervention that addresses continuity of care across settings/practitioners. Improve care transitions by providing patients with tools/support that promote knowledge/self-management of conditions as they move from hospital to home. Four week program, given tools/resources, supported by transition coach, and learn self-management. Led by Dr. Eric Coleman and CU, School of Medicine. | Patients ages 65+ | | ■ | | | | ■ | | |
| **Systems of Care Initiative** *Transitions of Care Program* | Looking at the implementation of a new community based care transitions program, primary goals for which are to improve patient health by increasing patient involvement in healthcare and to reduce: hospital admissions, emergency department admissions, acute episodes resulting from chronic diseases, and health care costs. Focus on elderly patients with chronic disease at high risk for readmission. | Elderly patients with chronic disease at highest risk for readmission | | ■ | | | | ■ | | |

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| **Colorado Foundation for Medical Care** *Integrating Care Populations & Communities* | Assist interested participants in forming relationships with community organizations and health care providers to achieve a set of common goals: reducing unnecessary hospital readmissions, improving information transfer between health care providers and patients, developing consistent workflow process, and increasing patient activation/satisfaction. Community based organizations will work with CFMC to lead a community in care transitions efforts. Funded by CMS and Community Based Care Transition Program. | Medicare | | ■ | | | | ■ | | |
| **St. Anthony Hospital/Centura** *ReConnect Leadership Project* | Started with a pilot project at St. Anthony Hospital/Centura that connected each patient with a coach prior to leaving a hospital (based study off of evidence base from Coleman Care Transition Intervention). Involves training of retiree-professionals as volunteers to provide care coordination in hospital to facilitate communication among patients, hospital associates, and physicians, and to educate patients during transition of care from hospital to home and provide self-management coaching. | St. Anthony/ Centura Patients | | ■ | | | | ■ | | |
| **Centura** *Centura Health at Home* | Centura Health at Home (CHAH) has integrated their existing home care services with a clinical call center that provides telehealth services. The call center is staffed by registered nurses, and showed success in reducing hospital readmissions , increasing patient self-management, and decreasing the number of nurse home visits. The integrated telehealth program is now standard of care for CHAH. | Home-based Centura Medicare beneficiaries | | ■ | | | | ■ | | |

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| **Rocky Mountain Health Plans** *Colorado Beacon Consortium Practice Transformation Team* | Demonstration program to expand HIE through Quality Health Network and provide a Practice Transformation Team including Quality Improvement Advisors to work with medical practices. This practice transformation will improve care coordination and care transition to increase efficiencies within medical practices, and support good health for the community. Office of the National Coordinator HITECH funded. | All Payers | | ■ | | | | | | ■ |
| **Colorado Regional Health Information Organization** *Long Term/Post-Acute Care Program to Improve Care Transitions through HIE* | Facilitates adoption and measures the impact of HIE on long-term and post-acute care transitions. Participating organizations (including skilled nursing facilities, assisted living residences, home health, hospice, long term acute care facilities, and REF-DD programs) will receive training/access for CORHIO HIE via web portal. Funded by HIE Challenge Grant by the Office of the National Coordinator. | All Payers | | ■ | | | | | | ■ |
| **Colorado Hospital Association** *Reducing Avoidable Hospital Readmits & Safe Transitions Collaborative* | Implementing interventions designed to re-engineer hospital workflow process and improve inpatient/outpatient safety through increased patient preparedness, enhanced provider-patient relationship, and improved community structure. First phase focuses on implementation of Project RED, second phase focuses on implementation of STAAR Initiative. Project intends to provide member hospitals/health systems with tools/training to spread this work to all areas of hospital and integrate as standard practice. Funded by UnitedHealthcare. | Heart failure, pneumonia patients, and other populations as selected by hospitals | | ■ | | | | | | ■ |

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| **Brookdale Senior Living Centers** *Transitions of Care Program* | Expand and test transitions of care program for residents living in independent living, assisted living and dementia-specific facilities and include community-dwelling adults receiving home health services from the lead agency. Program will launch in Texas and Florida, will expand to Brookdale facilities in Colorado and other states in later years. Funded through an award from the CMMI Innovation Challenge. | Residents living in independent living, assisted living, and dementia facilities | | ■ | | | | | | ■ |
| **Jefferson Center for Mental Health, Seniors' Resource Center, and Mental Health Partners** *Senior Reach* | Senior Reach Call Center is a single entry point (dedicated toll free phone number) to refer older adults for services. Staff gathers basic information from referral source and contacts the senior to explain the program, engage the senior in an elder-friendly manner, find out what needs the older adult may have (transportation, financial, etc.) and offer Senior Reach services. Combination of training for community members and skilled professionals. Grant funded. | Colorado Seniors, 60+ years old | | ■ | | ■ | | | | |
| **Colorado Foundation for Home Care** *Telehealth in the Home* | Delivery of telemedicine and telehealth services in the home setting for Medicaid clients. Participating home care agencies use telehealth devices to monitor Medicaid patients' health status and collect vital signs, educate patients, and remind them to take medications. Includes a chronic disease management component. Funded by the Colorado Health Foundation, with potential matching funds from CMS. | Medicaid | | ■ | | | | ■ | | ■ |
| **Boulder Valley Care Network** *Patient Centered Medical Community* | Collaboration of 600+ healthcare providers representing majority of providers in Boulder area. Goal is to provide effective, coordinated and affordable high quality care through efficient sharing of independent community healthcare resources, coordinating care, educating/supporting patients in their efforts towards being well/living healthy lifestyles. Specific initiatives: develop a local chronic disease management solution (nurse care coordinators); building capacity to use data (including high claims) to improve care (e.g. Prometheus); and improving the prescription drug program. Key partner is Cigna. Funding comes from shared savings. | Commercial | | ■ | | | | ■ | | ■ |

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| **Colorado Foundation for Medical Care** *Northwest Denver Care Transitions Initiative, "Connected for Health"* | Improve quality of care transitions for Medicare transitions between care settings. Focus on improving coordination of care between providers/care settings by promoting seamless transitions from hospital to home, skilled nursing care, home health care, and others to prevent avoidable rehospitalization. Participants standardize processes, increased patient engagement, created culture change and community coalitions, and facilitated the creation of a regional HIE. Funded by CMS. | Northwest Denver Medicare Clients | | ■ | | | | ■ | | ■ |
| **University of Colorado Denver & Health Sciences Center** *Assisting Older Adults with Transitions of Care* | Personal health record application to help sedentary older adults transitioning out of acute care settings who must manage complex medication regiments. The "Colorado Care Tablet" lets users track prescriptions through portable touch screen tablet with simplified screens and barcode scanner that recognizes medication labels. Being integrated with national data banks/personal health record platforms to ensure interoperability and paired with lessons learned at University of Colorado Hospital. | Medicare | | ■ | | | | ■ | | ■ |
| **Mesa County Area Agency on Agency** *Adult Resources for Care and Help (ARCH)* | Resource center for adults 60+ years (and 18+ years with disability), administered by Mesa County Area Agency on Aging. ARCH has "no wrong door" approach for accessing long term care services and community resources, achieved through extensive collaboration with community partners, accepting calls from any source. Provides services such as "Home Connections," community collaborative driven program that gives assistance in homes of qualified individuals to keep them safe/independent for as long as possible without needing costly long-term care. | Adults age 60+ in Mesa County | | ■ | | ■ | | ■ | | |

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| **CMMI** *Comprehensive Primary Care Initiative (CPCI)* | Multipayer PCMH initiative combining care coordination payments from Medicare with those from private payers for up to 75 primary care practices. Resources will be given to providers to promote a service delivery model that ensures care management for patients with high health care needs, access to care, delivery of preventive care, engagement of patients/caregivers, and coordination across the medical neighborhood. Also includes potential for shared savings. Four-year pilot, launching late summer 2012. The 9 Colorado payers: Anthem, CIGNA, Colorado Access, Colorado Choice Health Plans, CO Medicaid, Humana, Rocky Mountain Health Plans, Teamsters Multi-Employer Taft Hartley Funds, UnitedHealthcare. | Medicare, Medicaid, Commercially insured | | | ■ | | | | | |
| **Colorado Community Health Network** *Safety Net Medical Home Initiative* | 13 safety net clinics in Colorado are participating in this national PCMH demonstration. Funded by the Commonwealth Fund, Qualis Health and the MacColl Center for Healthcare Innovation. | Vulnerable | | | ■ | | | | | |
| **Centura** *Colorado Accountable Care* | This ACO launched in January 2013 and is in the process of implementation. The initiative is only offered in Centura facilities by Centura employees for now, but expansion outside the company is possible. The initiative focuses on shared savings determined though 33 quality measures with information gathered from a patient registry and EHRs. | Medicare-eligible Centura patient | | | ■ | | | | | |
| **Colorado Community Health Network** *National Committee for Quality Assurance PCMH Project* | Provides training and coaching to Colorado FQHCs applying for National Committee for Quality Assurance PCMH recognition. Technical assistance emphasizes patient centered care, patient self-management support, patient activation, enhanced communication between patients/providers. | All patients seen at the partner sites | | | ■ | | ■ | ■ | | |

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| **Engaged Public** *Engaged Benefit Design* | Strategy to increase value of health insurance benefits through provision of incentives to patients to seek and receive high value evidence based care, consider whether frequently overused services are right for them, and engage in shared decision making with their provider to make better informed care choices. Uses patient decision aids developed by the Informed Medical Decisions Foundation. Implemented in conjunction with Colorado Choice Health Plans/San Luis Valley HMO. Funded by the Robert Wood Johnson Foundation and the Colorado Dept. of Health Care Policy and Financing. | San Luis Valley Regional Medical Center employees | | | | | ■ | ■ | | |
| **Denver Health (CO lead)** *Engaging patients through shared decision making: using patient and family activators to meet Triple Aim* | Aims to collaborate with health care systems around the country to hire patient and family activators, trained to engage in shared decision making with patients/families. Multistate initiative funded through CMMI's Innovation Challenge, and led by the Dartmouth College Board of Trustees. | Denver Health patients | | | | | ■ | ■ | | |
| **CO Community Treatment Centers (CO lead)** *Using care managers and technology to improve the care of patients with schizophrenia* | Develop workforce capable of delivering effective treatments, using newly available technologies, to at risk high cost patients with schizophrenia. Test the use of care managers, physicians and nurse practitioners trained in new technology to treat patients in community treatment centers. Those trained will educate patients/caregivers about medication management, cognitive behavior therapy, and monitoring tools. Multistate initiative funded through CMMI's Innovation Challenge to the Feinstein Institute for Medical Research. | At-risk/high-cost patients with schizophrenia | | | | | | ■ | | ■ |

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| **Colorado Medical Society** *CO Collaborative Quality Improvement Project* | Collaborative effort in partnership with American Medical Association, and United Health Group/ United Healthcare demonstrating potential value of providing detailed, benchmarked claims data to enable physicians to evaluate data, identify high cost variations, and implement practice modifications to achieve savings and improve quality. | Commercial | | | | | | | ■ | |
| **Colorado Hospital Association/Colorado Behavioral Health Council** *Colorado Telehealth Network* | The Colorado Telehealth Network (CTN) is a high-speed medical grade connection currently connecting over 200 health care organizations. These organizations include hospitals, mental health centers, and other health clinics. This initiative facilitates participation in the COHRIO health information exchange network. The initiative is managed by CHA and is a collaboration between CHA and CBHC. CTN provides patient-centered care through video, voice, and electronic data transfer. Rural health care organizations can now utilize cloud-based electronic health record systems. All of Colorado's mental health centers are connected to CTN and can provide services to less accessible populations as well as keep data more secure than over traditional connections. | Colorado Telehealth Network | | | | | | | | ■ |
| **Upper San Juan Health Services District** *SW Colorado Cardiac and Stroke Care* | Improves cardiac and stroke care by providing telehealth access to cardiologists and neurologists and creating new cardiovascular clinical teams including community paramedics and telehealth clinicians. Funded through CMMI's Health Care Innovation Challenge. Lead organization Pagosa Springs Medical Center. | Cardiac/ Stroke patients in Archuleta County | | | | | | | | ■ |
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