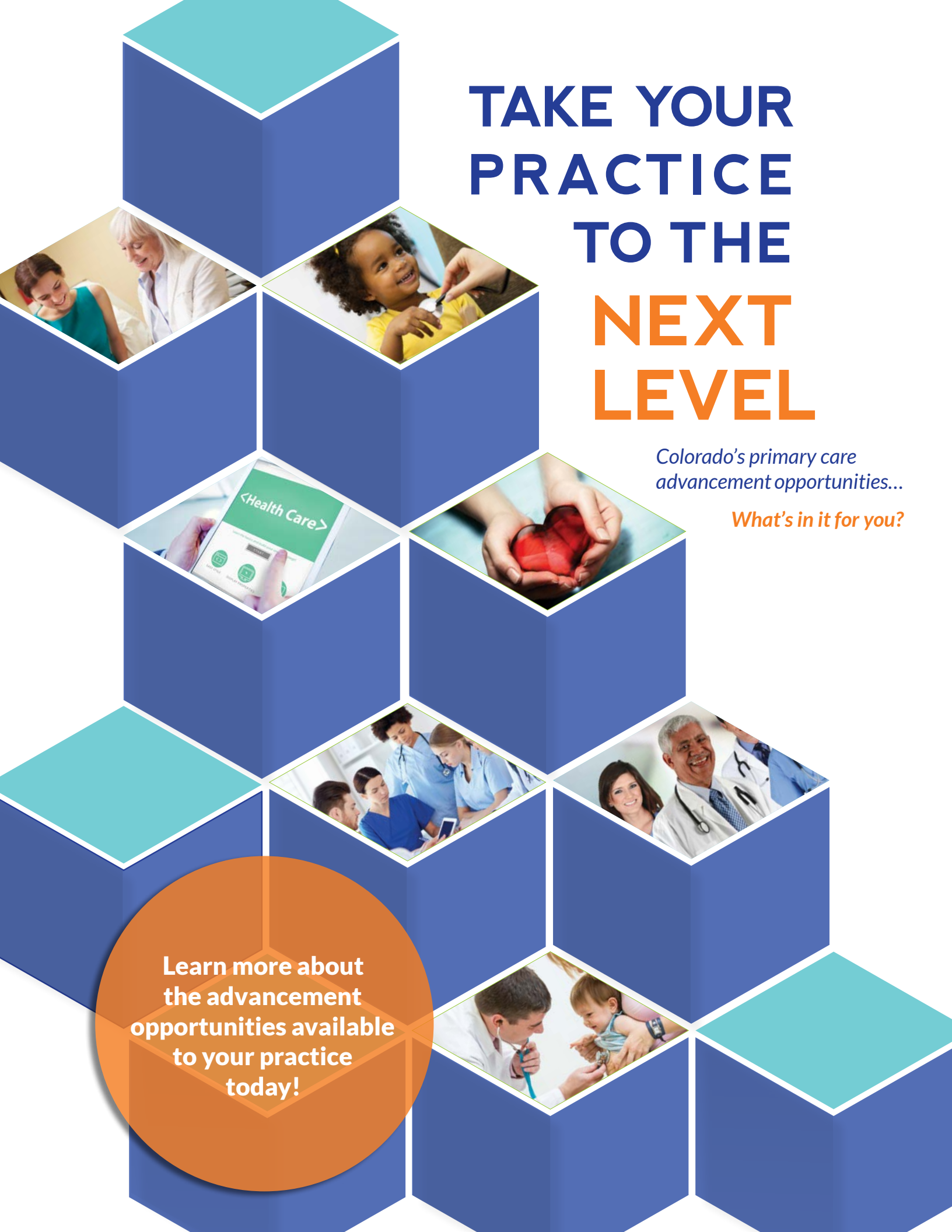


# TAKE YOUR PRACTICE TO THE NEXT LEVEL

*Colorado's primary care  
advancement opportunities...*

*What's in it for you?*



**Learn more about  
the advancement  
opportunities available  
to your practice  
today!**

# WHAT'S INSIDE?

*Don't sit by while your colleagues take advantage of one (or more) of the programs outlined here.*

2	How to use this guide
3	Where to begin
6	Foundation building opportunities
12	Advancement and evolution opportunities
18	Integration opportunities
23	Additional Offerings
26	Practice Transformation Organizations
32	Glossary
37	Appendix

**Keep reading to find out more about practice advancement programs that will help you:**

**IMPROVE YOUR WORKFLOW  
INCREASE OFFICE EFFICIENCY  
OPTIMIZE YOUR EHR  
ELEVATE PATIENT CARE**

## A MESSAGE FROM COLORADO PAYERS

Primary care is the foundation of any effective health care system. It is the place where most people receive care, where most prescriptions are written, and where long term, trusting relationships are built between patients and providers—often over the course of decades and generations. Primary care is also the only health care segment that is proactively focused on the maintenance of good health.

Colorado health plans value the efforts that primary care leaders are undertaking to advance their organizational skills and impact upon the health of the patients and populations they serve. This is hard work, but fundamental to the creation of better value for patients. Likewise, Colorado payers, Medicaid and Medicare are actively seeking new ways to recognize and collaborate to support advanced primary care practices—through enhanced payment, data aggregation and aligned measurement. We appreciate your leadership and partnership in this critical process of change. Thank you for considering participating in the learning opportunities outlined in this catalog.

This catalog shows what's available to support and advance primary care in the transformation process. Practices can enter at their own point of readiness and get on a trajectory that puts them in the best position to deliver and document value—value that's increasingly recognized and rewarded. The programs listed here share the same goal: to help practices achieve fundamental, sustainable change in how primary care is delivered in order to improve the health of the community.

*This catalog is provided by the Colorado Health Extension System, a collaborative, multi-stakeholder organization that seeks to improve health and health care across Colorado.*

# COLORADO PRACTICES ADVANCING CARE

Practices across the state are demonstrating their commitment to better health and health care for their patients.

Unprecedented support and resources are available to primary care practices that want to improve, change, redesign—transform—into examples of excellence in advanced patient-centered care. This guide reflects Colorado’s desire to establish a coordinated effort to effectively use and align new and existing resources to support practices in their efforts.

The menu of practice-advancement opportunities is diverse and the offerings are rich. You can expect to receive hands-on, in-person assistance with

- **using data for improvement;**
- **workflow analysis;**
- **office efficiency;**
- **optimizing your use of health information technology; and**
- **preparing for new compensation models.**

Many of these programs provide practice facilitation assistance and deliver skills-based training to practice staff that will enhance individual and group performance and enable physicians to be clinical leaders and mentors to the practice team. Participants can learn

- **how to engage patients in their own care using evidence-based self-management support techniques;**
- **care management and care coordination best practices; and**
- **motivational interviewing.**

Finally, practices can participate in a friendly, statewide peer-to-peer learning network focused on identification of best practices.

## HOW TO USE THIS GUIDE

Colorado practices are invited to use this guide to create an individualized learning curriculum that advances the competencies that are needed for high-performing primary care. In Colorado, high-performing primary care delivers measurable value to consumers, payers, and providers alike. The offerings presented in this catalog are categorized according to the content, designed in such a way that a practice, wherever it is on its trajectory toward high-performing primary care today, can choose a meaningful next step.\*



Practices actively seeking a trajectory that will put them in the best position to deliver and document value in the evolving care delivery and payment reform landscape can find meaningful offerings in this catalog. A practice self-assessment tool available on page 37 will help practices evaluate where to focus their efforts.

\* These steps are based on Bodenheimer T, Willard-Grace R, Ghorob A, Grumbach K. “The 10 building blocks of high-performing primary care.” *Ann Fam Med*. 2014;12(2):166–171

# WHERE TO BEGIN

If you are a practice that has not been involved in quality-improvement or practice-transformation activities, or if you just want to really assess what your practice strengths and gaps related to delivery of high performing primary care are, begin by completing the practice self-assessment tool that begins on page 37.

If you are a practice that has been trying out some activities related to improving outcomes or care, then Category 1 offerings will likely provide you options to consider.

If you are a practice that has been actively engaged in quality-improvement initiatives, have started to identify the subpopulations of patients in your practice, and currently routinely evaluate your own practice performance, Category 2 or Category 3 may be where you can find support offerings that will help you meet your advancement objectives. Many of the offerings span multiple categories, in which case they are listed only once—in the higher number category (as defined by the offering organization).



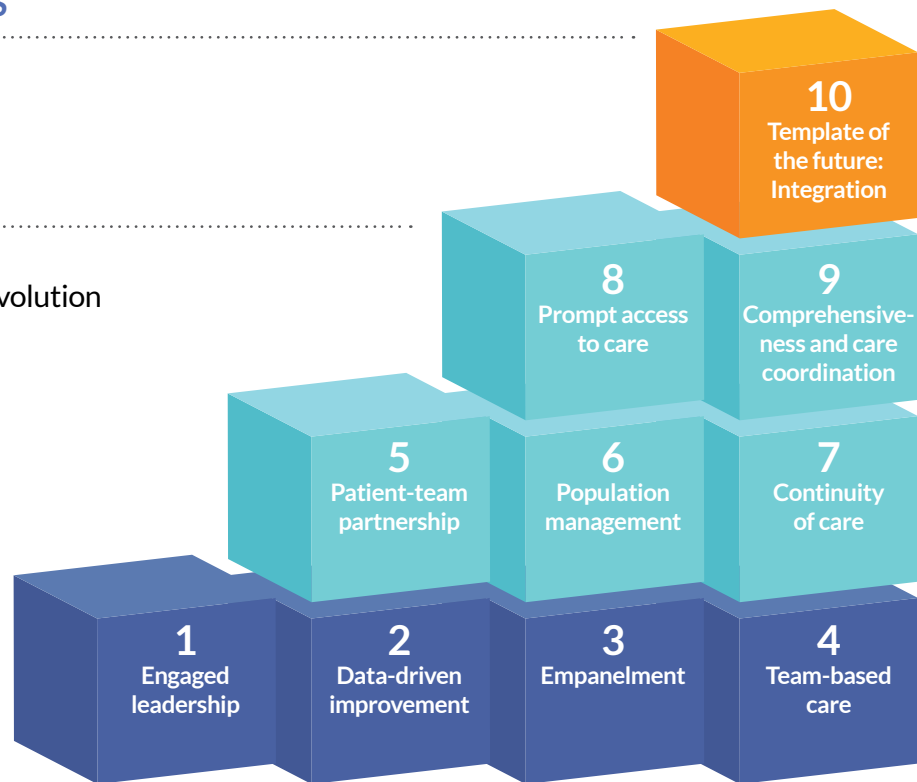
**Figure 1a. High-Performing Primary Care**

**PRACTICE ROLES**

**Category 3:**  
Integration

**Category 2:**  
Advancement and Evolution

**Category 1:**  
Foundation Building



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

**KEY COMPETENCIES FOR EACH STEP OF HIGH-PERFORMING PRIMARY CARE**

**Category 1: Foundation Building**

**1. Engaged Leadership**

- Clear vision, strategy, capacity, capability, and priority for change
- Strong practice culture that stimulates innovation
- Effective business processes to support new models of care and payment

**2. Data-driven Improvement**

- Advanced measurement and goals-setting capabilities
- Effective use of data and other quality-improvement techniques/tools
- Optimized use of all available health information technology

**3. Empanelment**

- Ongoing process of assigning accountability for each active patient to a provider/team
- Patient panels as foundation for individual/population health management
- Relationship continuity

**4. Team-Based Care**

- Staff performing at the top of licensure with clear role definitions
- Enhanced staff resources
- Workflow maximizes use of resources

**Category 2: Advancement and Evolution**

**5. Patient-Team Partnership**

- Maximum engagement of expertise/experience of patients and caregivers
- Effective use of shared decision making, self-management support, patient activation
- Clinician expertise/judgment as a part of effective partnership

**6. Population Management**

- Stratification of population based on needs
- Team roles based on stratified needs
- Panel management, health coaching, complex care management/coordination

**7. Continuity of Care**

- Empanelment
- Measurement
- Relationships

**8. Prompt Access to Care**

- Reduced patient waiting
- Timely access to needed information
- Alternative access to team-based care for additional capacity

**9. Comprehensiveness and Care Coordination**

- Management of transitions and referrals
- Care coordination as a role
- Bi-directional communication processes

**Category 3: Integration**

**10. Template of the Future: Integration**

- Effective integration (behavioral health, community)
- Comprehensive payment model
- Ongoing learning and diffusion

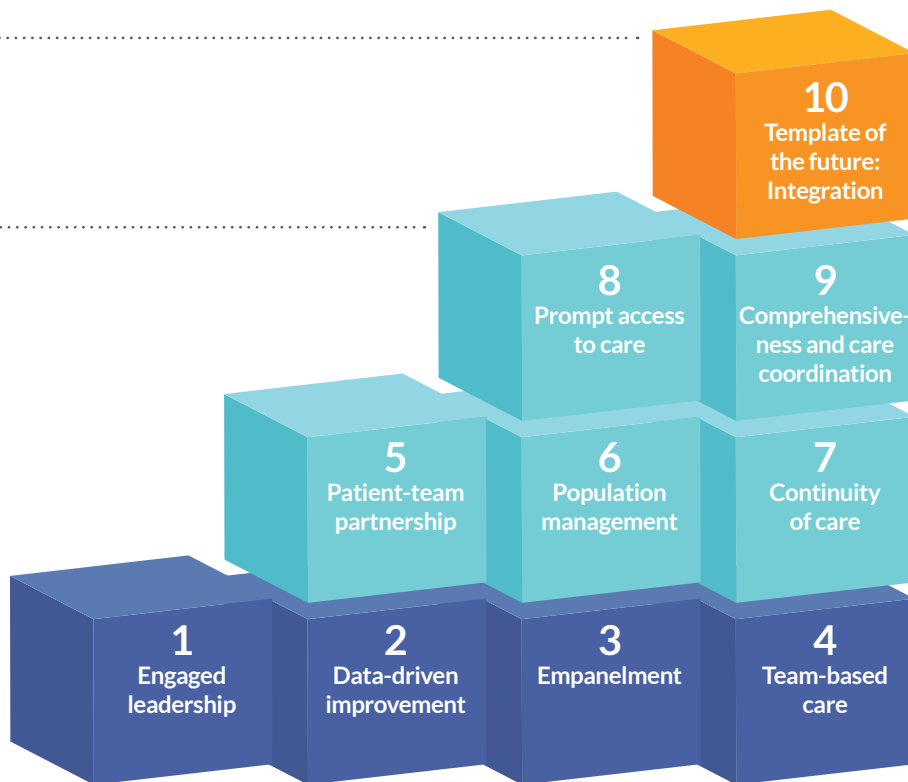
**Figure 1b. High-Performing Primary Care**

**PAYER ROLES**

**Category 3:**  
Integration

**Category 2:**  
Advancement and Evolution

**Category 1:**  
Foundation Building



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

**PAYER SUPPORT FOR ADVANCING HIGH-PERFORMING PRIMARY CARE**

**Category 1: Foundation Building**

- Support application for state and federal programs by practices and/or CHES
- Promote the delivery of offerings to build foundational expertise and workflows in practices
- Promote development of statewide practice transformation network (CHES) availability to practices

**Category 2: Advancement and Evolution**

- Active collaborative multi-payer work to engage multiple payers in some level of enhanced payment/ value-based contracting
- Collectively provide effective data-sharing/aggregation services
- Align measurement
- Individual payer initiatives to support above

**Category 3: Integration**

- Recognize advanced models and advanced practices
- Support research and development (proof of value)
- Develop/deploy comprehensive payment

# category 1



## FOUNDATION BUILDING

*Building processes and infrastructure; developing core competencies essential to support advanced primary care functions, such as Team-Based Care, Leading for Change, and using Data for improvement. Examples include maximizing use of the EMR; embedding Quality-Improvement processes; developing measurement capabilities; enhancing data quality; health information exchange (HIE) support; and developing solid business processes to support advanced models of care and payment.*

# FOUNDATION BUILDING OPPORTUNITIES

## *Why would a practice be interested in foundation building?*

Within the foundation-building (Category 1) offerings, practices can find support for initiating activities that build necessary competencies around effective leadership; strong business processes; and effectively utilizing their EMR, registry functionality, and HIE linkages and data. Practices can work on building effective care teams; learn to effectively and efficiently work on improving processes, outcomes and measurement; and assign patients to care teams who accept primary responsibility for those patients.

### CDPHE Chronic Diseases and School Health Grant

**Focus:** Part of CDPHE Clinic Quality Improvement for Population Health (CQI) Initiative. Grant focuses on health system change and clinical quality improvement to implement evidence-based interventions related to the management of hypertension and diabetes, including measurement and extraction of data.

**Offered by:** CDPHE

**Funded by:** Centers for Disease Control and Prevention

**Availability:** Available to 10-20 clinics per year through 2018.

**Practice Incentives:** Reimbursement of staff time and infrastructure to implement QI scope of work. Average reimbursement is less than or equal to \$5,000 per clinic system depending on prioritized QI intervention. Up to 12 CME credits available for free to those professionals who complete the PCMH e-learning modules as part of their QI work.

**Practice Commitments:** Targeted Health Systems Change and Clinical Quality Improvement to improve measurement and reporting of NQF #0018 and NQF #0059; chart audit compared to EHR data pull and analysis (combined with Colorectal, WWC, and tobacco for comprehensive evaluations); maximizing HIT (data extraction, registry development, POC reminders, patient reminders); policies and procedures and workflow and process improvement (may include inclusion of non-traditional team, self-management plans (DSME), medication management, Diabetes Prevention Program referral (DPP)).

**Contact:** Brooke Bodart: Brooke.Bodart@state.co.us

### CDPHE Colorectal Cancer Grant

**Focus:** Part of CDPHE Clinic Quality Improvement for Population Health (CQI) Initiative. Grant focuses on health systems change and clinical quality improvement to implement evidence based interventions related to colorectal cancer screening and follow-up.

**Offered by:** CDPHE

**Funded by:** Centers for Disease Control and Prevention

**Availability:** Approximately 10 clinics per year through June 2020.

**Practice Incentives:** Reimbursement of staff time and infrastructure to implement QI scope of work. Average reimbursement is less than or equal to \$5,000 per clinic system depending on prioritized QI intervention.

**Practice Commitments:** Interventions include maximizing HIT (data extraction, registry development, POC reminders, and patient reminders); policies and procedures and workflow and process improvement. Assist in improving colorectal cancer screening rates using NQF 0034.

**Contact:** Kelly Means: Kelly.Means@state.co.us

### CDPHE Falls Risk

**Focus:** Screening and Intervention (Primary and Secondary) for falls in adults >65 years of age

**Offered by:** CDPHE

**Funded by:** Centers for Disease Control and Prevention

**Availability:** Open

**Practice Incentives:** None specified



**Practice Commitments:** The STEADI Toolkit is designed to engage providers to assess risk of falls and to create a plan of care to reduce fall risk. The CDC has a 1-hour online, free training for healthcare professionals through CDCTrain. To access the course visit: <https://cdc.train.org> and enter STEADI in the search field. CDPHE also provides in person-trainings, technical assistance and resources to providers. Providers can refer patient to evidence-based programs that are taking place in the community using an established online/telephone/fax referral system.

**Contact:** [aerin.lacerte@state.co.us](mailto:aerin.lacerte@state.co.us), 303-692-2530

### CDPHE Tobacco

**Focus:** Tobacco Cessation and Counseling

**Offered by:** CDPHE

**Funded by:** Centers for Disease Control and Prevention & A35

**Availability:** Available to approximately 10-20 clinics per year through 2018 plus connection to community-based efforts to support cessation counseling and a third-party contract focused on TA for RCCOs and Medicaid provider education.

**Practice Incentives:** None specified

**Practice Commitments:** Targeted Health Systems Change and Clinical Quality Improvement to tobacco screening and counseling rates; chart audit compared to EHR data pull and analysis (combined with hypertension and diabetes, WWC, colorectal, and tobacco for comprehensive evaluations); maximizing HIT policies and procedures and workflow and process improvement, connection to other A35 grantees in community.

**Contact:** Brooke Bodart: [Brooke.Bodart@state.co.us](mailto:Brooke.Bodart@state.co.us)

### CDPHE WISEWOMAN

**Focus:** Part of CDPHE CQI Initiative. Grant focuses on health systems change and clinical quality improvement to implement evidence-based interventions related to hypertension control, diabetes control and tobacco use and assessment.

**Offered by:** CDPHE

**Funded by:** Centers for Disease Control

**Availability:** Open to clinics in Adams, Elbert, Huerfano, Kit Carson, Las Animas, Lincoln, Logan, Morgan, Prowers, Pueblo, and Weld Counties. Available to approximately 30 to 50 clinic systems over a 4-year period based on funding (10 clinics per year through June 2017). Clinic partners will be identified in first three years with continued engagement with clinic systems to implement evidence-based interventions for hypertension control, diabetes control and tobacco use and assessment.

**Practice Incentives:** None specified

**Practice Commitments:** Interventions include maximizing HIT (data extraction, registry development, POC reminders, and patient reminders); policies and procedures and workflow and process improvement. Assist in improving hypertension control rates using NQF 0018.

**Contact:** [Kelly.Means@state.co.us](mailto:Kelly.Means@state.co.us)

### CDPHE Women's Wellness Connection (WWC)

**Focus:** Part of CDPHE CQI Initiative. Grant focuses on health systems change and clinical quality improvement to implement evidence-based interventions related to breast and cervical cancer screening and follow-up.

**Offered by:** CDPHE

**Funded by:** Centers for Disease Control & A35

**Availability:** Available to approximately 30 to 50 clinic systems over 5-year period based on funding (5-10 clinics per year through June 2017). Clinic partners will be identified in first three years with continued engagement with clinic systems to implement evidence-based interventions for breast and cervical cancer screening and follow-up.

**Practice Incentives:** None specified

**Practice Commitments:** Interventions include maximizing HIT (data extraction, registry development, POC reminders, and patient reminders); policies and procedures and workflow and process improvement. Assist in improving breast and cervical cancer screening rates using NQF 0032 and 2372.

**Contact:** Kelly Means: [Kelly.Means@state.co.us](mailto:Kelly.Means@state.co.us)

### ClinicNET's Healthy Clinic Assessment

**Focus:** Strengthen affiliate safety net clinics through an on-site assessment, a subsequent report with clinic scores outlining practical recommendations and consultation to identify and recommend best practices for increased efficiencies. Examples include: integrating siloed workflows; empaneling patients; deploying processes for effective patient flow; developing an effective scheduling system to decrease appointment no-shows; increasing capacity by utilizing clinician time to their maximum scope of practice; training and support for a culture of quality improvement; and practice transformation clinic-wide.

**Offered by:** ClinicNET

**Funded by:** Local funders

**Availability:** Up to 10 affiliate clinics per year.

**Practice Incentives:** None specified

**Practice Commitments:** Variable based upon clinic needs. Typical assessment and related consultation is 8-10 hours. Support up to ten affiliate clinics per year through grant funding to provide healthy clinic assessments, with scores and practical recommendations, educational webinars, blogs, collaborative and networking opportunities, and resources and tools for its affiliates.

**Contact:** Cathryn Benedict, cathryn.benedict@clinicnet.org 720-280-0997

### ClinicNET's Practice Transformation Consulting

**Focus:** ClinicNET provides a continuum of services and resources based on affiliate clinic specific care delivery models and transformation requests. These include aligning with or meeting the objectives of Colorado initiatives or incentive programs, federal initiatives or incentive programs, clinic funding objectives, integration of services, and/or implementing a team-based care model. ClinicNET will meet with, assess and evaluate basic business operations and develop a plan with designated clinic staff to meet affiliate clinic specific objectives, i.e. enhancing workflows, developing empanelment processes, cultivating culture of quality improvement and/or providing resources and tools to reach patient care objectives.

**Offered by:** ClinicNET

**Funded by:** Local funders

**Availability:** Up to 10 affiliate clinics per year.

**Practice Incentives:** None specified

**Practice Commitments:** Variable depending on clinic needs, size and scope of services. In addition ClinicNET offers educational webinars, blogs, shared learning and networking opportunities, and resources and tools for its affiliates.

**Contact:** Cathryn Benedict: cathryn.benedict@clinicnet.org 720-280-0997

### CORHIO and QHN Colorado Care Connections Program

**Focus:** Connection to CORHIO HIE: Meaningful Use consulting, technical assistance with EHR workflow issues

Connection to QHN HIE: HIE enrollment, training, patient notifications, single sign on, direct messaging, image enablement, patient subscription, EHR interfaces, electronic ordering, delivery of CCD or CCD-A, Data mapping to support specific tools, e.g., pop health, care coordination, patient risk, referrals.

**Offered by:** CORHIO/QHN

**Funded by:** Colorado Department of Health Care Policy and Finance (HCPF)

**Availability:** Ongoing enrollment: through June 2017

**Practice Incentives:** CORHIO ONLY: \$5,000 upon completion of bi-directional connection within a year of signing the agreement. Two years of monthly HIE connection fee waiver for up to 5 providers.

**Practice Commitments:** No specific practice commitments, except to sign the letter of agreement

**Contact:** Front Range: Drew Currie, Dcurrie@corhio.org  
Western Slope: support@qualityhealthnetwork.org

### CORHIO Colorado Regional Extension Center CO-REC

**Focus:** Selection, implementation and meaningful use of EHRs.

**Offered by:** CORHIO and REC Partners

**Funded by:** Office of the National Coordinator for Health Information Technology (ONC)

**Availability:** Open to individual or small group primary care, OB/GYN, and pediatric practices. On-going enrollment through April 2016.

**Practice Incentives:** None specified

**Practice Commitments:** Variable. Work with REC consultant to meet MU requirements.

**Contact:** Kelly Procopio, Transformation Support Services Director kprocopio@corhio.org, 720-285-3251

### Duke/J&J Advanced Practice Nursing Fellowship

**Focus:** Focus is on leadership development for APNs leading clinical enterprises

**Offered by:** University of Colorado College of Nursing

**Funded by:** Johnson and Johnson

**Availability:** 20-30 Advance Practice Nurses per year

**Practice Incentives:** none specified

**Practice Commitments:** One year

**Contact:** Amy Barton, College of Nursing University of Colorado Anschutz Medical Campus, amy.barton@ucdenver.edu

### Healthy Clinic Improvement Program

**Focus:** Focus on technical assistance to Colorado's rural clinics throughout the state in the areas of basic business operations and quality improvement.

**Offered by:** Colorado Rural Health Center

**Funded by:** Kaiser Permanente

**Availability:** Ongoing enrollment for rural practices through September 2016.

**Practice Incentives:** None specified

**Practice Commitments:** Participation in designated project activities.

**Contact:** Jen Dunn, Director of Programs, [jd@coruralhealth.org](mailto:jd@coruralhealth.org), [www.coruralhealth.org](http://www.coruralhealth.org)

### Improving Prevention Coordination through Meaningful Use of HIT

**Focus:** Assisting providers to align processes to avoid penalties and receive incentive payments in pay-for-performance initiatives Meaningful Use (MU), Physician Quality Reporting.

**Offered by:** Telligen

**Funded by:** QIO-QIN project funded by Center for Medicare/Medicaid Services working with CORHIO and CO-REC partners

**Availability:** No limit of practice size or type of provider. Recruitment of providers who have not yet attested to MU, need help attesting to the next stage or have not reported PQRS and those serving minority and rural populations. Available Aug 1, 2014 start date with continual work through July 31, 2019.

**Practice Incentives:** None specified

**Practice Commitments:** Fill out provider agreement. QIO-QIN project funded by Center for Medicare/Medicaid Services working with CORHIO and CO-REC partners. Time—up to practice. Data collected from EHR MU reports but just reviewed at practice. Learning sessions optional. Webinars will be offered at no cost and optional.

**Contact:** [Devin.detwiler@hcqis.org](mailto:Devin.detwiler@hcqis.org), 303-875-9131

### Institute for Healthcare Quality, Safety, and Efficiency

**Focus:** Focus is on team-based quality improvement for acute care and ambulatory care teams.

**Offered by:** University of Colorado College of Nursing / Dept. of Internal Medicine

**Funded by:** Internally funded

**Availability:** University of Colorado Hospital and Clinics and Children's Hospital and Clinics

**Practice Incentives:** none specified

**Practice Commitments:** One year

**Contact:** Gail Armstrong, College of Nursing University of Colorado, Anschutz Medical Campus, [gail.armstrong@ucdenver.edu](mailto:gail.armstrong@ucdenver.edu)

### Rocky Mountain Health Plans Foundations

**Focus:** Improve/develop and implement skills, processes, and infrastructure to support ongoing improvement and the delivery of effective and efficient primary care.

**Offered by:** Rocky Mountain Health Plans

**Funded by:** Rocky Mountain Health Plans

**Availability:** Available to RMHP practices on Western Slope. Practice Transformation Team reviews and evaluates applications against program rubric. 12-month curriculum, ongoing enrollment. Starts twice a year, January or July. Application submission timeframes are November and December for a January start, and May and June for a July start.

**Practice Incentives:** CMEs available (AMA PRA Category 1 CMEs for Learning Collaboratives and 20 Performance Improvement CMEs). MOCs available.

**Practice Commitments:** Practice agrees to have a Quality Improvement team who meets twice a month with the RMHP Quality Improvement Advisor (once in person and once by phone), submit reports quarterly, participate in 2 Learning Collaboratives and share lessons learned. Quarterly reporting consists of a suite of 17 Clinical Quality Measures aligning with CMS, DHS, NQS and HIT and assessed against the six domains based on the NQS's six priorities. Three day-long Learning Collaboratives are offered throughout the year. Webinars are offered based on identified practice needs. Practices work on decided interventions from meeting with QIA.

**Contact:** [Cynthia.Mattingley@rmhp.org](mailto:Cynthia.Mattingley@rmhp.org)

### Rocky Mountain Health Plans Foundations for Specialty Practices (Pilot)

**Focus:** Improve/develop and implement skills, processes, and infrastructure to support ongoing improvement and the delivery of effective and efficient care.

**Offered by:** Rocky Mountain Health Plans

**Funded by:** Rocky Mountain Health Plans

**Availability:** Open to RMHP specialty practices on the Western Slope. Practice Transformation Team reviews and evaluates applications against program rubric. Available to approximately 5-10 specialty practices. Application submission timeframes are May and June for a July start. 12-month curriculum.

**Practice Incentives:** \$10,000 compensation divided and dispersed quarterly upon deliverables met. CMEs available (AMA PRA Category 1 CMEs for Learning Collaboratives and 20 Performance Improvement CMEs). MOCs available.

**Practice Commitments:** Practice agrees to have a Quality Improvement team who meets twice a month with the RMHP Quality Improvement Advisor (once in person and once by phone), submit reports quarterly, participate in 2 Learning Collaboratives and share lessons learned and best practices. Quarterly reporting consists of a suite of 17 Clinical Quality Measures aligning with CMS, DHS, NQS and HIT and assessed against the six domains based on the NQS's six priorities. Three-day Learning Collaboratives are offered throughout the year. Webinars are offered based on identified practice needs.

**Contact:** Cynthia.Mattingley@rmhp.org

## Technology for Healthcare Excellence Consortium

**Focus:** Focus on assisting rural facilities with HIT issues including EHR optimization/implementation, business intelligence/analytics, remote hosting, helpdesk support, quality data reporting, and education through webinar offerings and technical assistance.

**Offered by:** Colorado Rural Health Center

**Funded by:**

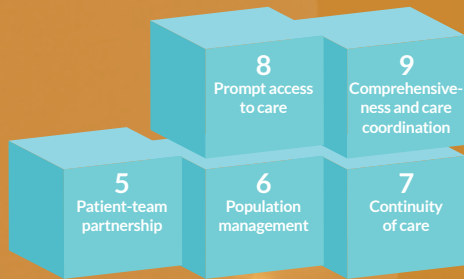
**Availability:** Available to all rural practices.

**Practice Incentives:** None specified

**Practice Commitments:** Practice commitments depend on service requested. Some services free; other fees vary by service needs.

**Contact:** Michelle Mills, CEO, mm@coruralhealth.org, www.coruralhealth.org

## category 2



# ADVANCEMENT & EVOLUTION

*Advancing key activities such as patient/caregiver engagement, population management, continuity of care, risk-stratification for comprehensive care management and care coordination, prompt access to care.*

# ADVANCEMENT & EVOLUTION OPPORTUNITIES

## *Why would a practice be interested in advancement and evolution ?*

The Advancement and Evolution offerings represent a level of advancement that begins to demonstrate high value in terms of relationships between the practice and the patient/caregiver and between the practice and the “medical neighborhood” or community. These offerings require substantial commitment and work toward developing and deploying key processes such as advanced access to care, risk stratification, continuity, and care management and care coordination.

### **Cardiac Health Project**

**Focus:** Focus on improving Cardiac Health eCQM/PQRS/NQF measures for Tobacco Use and Cessation, Aspirin/Antithrombotic Use in IVD patients, Blood Pressure Control for Hypertensive patients and Fasting LDL testing and Risk Stratification.

**Offered by:** Telligen

**Funded by:** QIO-QIN project funded by Center for Medicare/Medicaid Services working with CORHIO and CO-REC partners.

**Availability:** Available to providers who want to improve Clinical quality measures and those serving minority or rural populations. MUST have Medicare patients; no limit of practice size or type of provider. Open enrollment through July 31, 2019.

**Practice Incentives:** None specified

**Practice Commitments:** Complete provider agreement. Measures: ABCS—Aspirin Use/Anti- thrombotic use in IVD. Blood Pressure Control. LDL Risk Stratification. Smoking Use and Cessation. Data collected from EHR. Learning sessions optional. Webinars—many will be offered at no cost and optional.

**Contact:** Devin.detwiler@hcqis.org. 303-875-9131

### **Colorado Children’s Health Access Program (CCHAP) Administrative and Clinical Transformation Coaching for Medical Homes (Primary Care Practices) for Children in Colorado**

**Focus:** CCHAP provides practice coaching for any primary care practice or clinic that serves children covered by Medicaid or SCHIP in Colorado. Practice coaching includes all aspects of care: clinical, preventive care, screening, early intervention, billing, coding, reimbursement, administrative issues, policies procedures, immunization. Assistance in meeting medical home standards and key performance indicators. Provides problem-solving by phone. Provides updates via newsletters every 2 weeks and learning collaboratives every other month.

**Offered by:** CCHAP

**Funded by:** Local foundations and contracts with RCCOs

**Availability:** We can provide coaching for up to 50 Pediatric and Family Primary Care Practices at a time in this program.

**Practice Incentives:** None specified

**Practice Commitments:** There are no specific requirements for practice other than filling out an annual satisfaction survey. Practice moves at its own pace. One time in-office training followed by telephone support and biweekly newsletters and bimonthly webinar. Additional office visits on request. CCHAP provides ongoing consultation.

**Contact:** Anita.Rich@childrenscolorado.org

## Colorado Community Health Alliance— Practice Transformation: Advancement and Evolution

**Focus:** Colorado Community Health Alliance is committed to helping practices build sustainable processes to deliver comprehensive, patient-centered care through data and continuous quality improvement initiatives and the promotion of care coordination and team-based care.

Through Practice Transformation: Advancement and Evolution, Colorado Community Health Alliance will:

- Facilitate practices in developing and implementing clinical quality improvement initiatives that include the use of data to drive the following goals:
  - Improve patient access to the right care at the right time
  - Promote team-based, patient-focused care
  - Improve population management of chronic medical conditions
- Assist practices in optimizing electronic health records
- Promote coordination of care with specialists, community resources (including provision of Colorado Community Health Alliance care coordinators)

**Offered by:** Colorado Community Health Alliance (RCCO 6)

**Funded by:** Colorado Community Health Alliance (RCCO 6)

**Availability:** Available to all practices contracted with Colorado Community Health Alliance (RCCO 6); eligibility criteria may apply.

**Practice Incentives:** None specified

**Practice Commitments:** Practice must work on Key Performance Indicators established by the Colorado Medicaid ACC Program. Practice has established quality improvement and process improvement practices. Practice is committed to team-based, patient-centered care. Practice engages in services provided by the Colorado Community Health Alliance care coordination team. Practice commits to completing a Behavioral Health Readiness Assessment and displays willingness to progress in behavioral health integration.

**Contact:** Katy Valenty-Burlingame, Katy.burlingame@pmpcs.com

Zula Solomon, Zula.Solomon@pmpcs.com

## Colorado Rural Health Center Improving Communications and Readmissions (iCARE)

**Focus:** Focus on technical assistance aimed at improving communication in transitions of care, reducing avoidable

readmission rates, and improving clinical processes for chronic disease populations including diabetes, pneumonia, CHF.

**Offered by:** Colorado Rural Health Center

**Funded by:** Multiple sources

**Availability:** Available to all rural facilities. Open enrollment.

**Practice Incentives:** None specified

**Practice Commitments:** Participation in monthly project webinars, best-practice sharing, and data.

**Contact:** Jen Dunn, Director of Programs, jd@coruralhealth.org, www.coruralhealth.org

## Colorado Children's Health Access Program (CCHAP)—Coordinating All Resources Effectively (CARE) for Children with Medical Complexity

**Focus:** CCHAP provides coaching and support to enable practices and clinics with high numbers of children on Medicaid with medical complexity to develop registries, stratify patients to identify patients needing care coordination, track improvement and report outcomes, support families, implement effective transitions to specialists, specialty clinics and hospitals, decrease re-hospitalizations and ED visits, all in a sustainable manner.

**Offered by:** CCHAP

**Funded by:** CMMI award through the Children's Hospital Association. Also funded by Children's Hospital Colorado.

**Availability:** Limited to 6 practices or clinics.

**Practice Incentives:** Expected PMPM—amount undetermined at this time

**Practice Commitments:** Practices should be willing to stratify patients, create care plans, work with care coordinator and social worker from Children's Hospital, and work with evaluators to collect outcome data. Three year program/commitment.

**Contact:** Anita.Rich@childrenscolorado.org

## EvidenceNOW Southwest

**Focus:** A focus on building strong primary care practices able to implement new evidence-based interventions initially focusing on cardiovascular risk reduction. This program is an opportunity for grant-funded in-office practice facilitation to enhance effective team-based care, patient engagement skills, improve quality measures, and other primary care competencies.

**Offered by:** Transformation facilitation and HIT/HIE support provided by CHES partner organizations.

**Funded by:** Agency for Healthcare Research and Quality (AHRQ)

**Availability:** EvidenceNOW SW will support 208 Colorado practices in the following cohorts:

- Nov 2016—70 practices
- June 2016—70 Practices
- Nov 2016—68 Practices

**Practice Incentives:** \$500 stipend for participating in the evaluation process. CME available for participation in learning sessions. Potential credit towards Maintenance of Certification (fees may apply).

**Practice Commitments:** Allocate two to three hours per month for 9 months to engage with practice facilitator to adopt PCOR findings related to reduction of cardiovascular risk for patients in your practice.

Submit required measures.

Assign one provider and at least one staff member to be practice “champions.” They will attend 2 regional learning sessions in 9 months.

**Contact:** stacy.kramer@ucdenver.edu

### CCHAP: Pediatric Care Coordination Training

**Focus:** Provide Care Coordination Training to interested RCCO practices and community organizations as determined by the RCCO, focused on pediatric issues including waivers, developmental needs of children and families, care planning, community resources and problem solving. For practices in RCCO Regions 2, 3, 5, and 7.

**Offered by:** CCHAP

**Funded by:** RCCOs 2,3,5,7

**Availability:** Capacity to support 25-30 individual FQHCs, pediatric and family practices each year through June 2017. Rolling entrance into program.

**Practice Incentives:** None specified

**Practice Commitments:** Three levels of training each involving a one-day training and telephone-based continued learning. Training occurs in small groups.

**Contact:** To apply contact your RCCO or CCHAP Anita. Rich@childrenscolorado.org

### Physician Health Partners—Practice Transformation: Advancement and Evolution

**Focus:** Physician Health Partners is committed to helping practices build sustainable processes to deliver comprehensive, patient-centered care through data

and continuous quality improvement initiatives and the promotion of care coordination and team-based care.

Through Practice Transformation: Advancement and Evolution, Physician Health Partners will:

- Facilitate practices in developing and implementing clinical quality improvement initiatives that include the use of data to drive the following goals:
  - Improve patient access to the right care at the right time
  - Promote team-based, patient-focused care
  - Improve population management of chronic medical conditions
- Support practices in National Committee for Quality Assurance (NCQA) recognition programs for diabetes, heart/stroke, and patient-centered medical home
- Assist practices in optimizing electronic health records and Meaningful Use
- Promote coordination of care with specialists, community resources (including provision of Physician Health Partners care coordinators)

**Offered by:** Physician Health Partners

**Funded by:** Physician Health Partners

**Availability:** Available to all primary care practices that are members of one of the Independent Practice Associations (IPA) supported by Physician Health Partners; IPA membership is open to eligible primary care providers upon request.

**Practice Incentives:** None specified

**Practice Commitments:** Practice must meet Physician Health Partners IPA goals and requirements. Practice commits to engaging a quality improvement (QI) team that includes a provider champion. Practice engages in an ongoing relationship with a Physician Health Partners QI coach and agrees to have regular, at least monthly, QI team meetings that drive QI initiatives and progress. Practice engages in services provided by the Physician Health Partners care coordination team.

**Contact:** Katy Valentyn-Burlingame:Katy.burlingame@phpmcs.com

Zula Solomon: Zula.Solomon@phpmcs.com

### Rocky Mountain Health Plans Masters 1

**Focus:** Practices will build and utilize skills and infrastructure that are consistent with a comprehensive primary care approach. This will focus on care management of high-risk patients and coordination of care across the medical neighborhood.

**Offered by:** Rocky Mountain Health Plans



**Funded by:** Rocky Mountain Health Plans

**Availability:** Available to approximately 10-15 RMHP primary care practices on the Western Slope. Ongoing enrollment. Practice Transformation Team reviews and evaluates applications against program rubric. Application submission timeframes are May and June for a July start. Starts twice a year, January and July.

**Practice Incentives:** \$10,000 compensation divided and dispersed quarterly upon deliverables met. CMEs available (AMA PRA Category 1 CMEs for Learning Collaboratives and 20 Performance Improvement CMEs). MOCs available.

**Practice Commitments:** 12-month curriculum. Practice agrees to have a Quality Improvement team that meets twice a month with the RMHP Quality Improvement Advisor (once in person and once by phone), submit reports quarterly, participate in Learning Collaboratives and share lessons learned and best practices as well as develop written processes for empanelment of all active patients, risk stratification of all RMHP patients, care management with focus on ED visits and hospital discharges.

**Contact:** Cynthia.Mattingley@rmhp.org

### Rocky Mountain Health Plans Masters 2

**Focus:** Practices will continue to enhance and utilize the skills and infrastructure that are consistent with a comprehensive primary care approach. Further, practices will expand their focus on care management of high-risk patients, care coordination across the medical neighborhood, patient engagement, and overall experience of care.

**Offered by:** Rocky Mountain Health Plan

**Funded by:** Rocky Mountain Health Plans

**Availability:** Available to approximately 10-15 RMHP primary care practices on the Western Slope. Ongoing enrollment. Practice Transformation Team reviews and evaluates applications against program rubric. Application submission timeframes are May and June for a July start. Starts twice a year, January and July.

**Practice Incentives:** \$10,000 compensation divided and dispersed quarterly upon deliverables met. CMEs available (AMA PRA Category 1 CMEs for Learning Collaboratives and 20 Performance Improvement CMEs). MOCs available.

**Practice Commitments:** 12-month curriculum. Practice agrees to have a Quality Improvement team who meets twice a month with the RMHP Quality Improvement Advisor (once in person and once by phone) to continue Master's 1 work. In addition, focus efforts on:

- patient experience activity such as PFAC, shared decision making tools and patient surveys.
- submit reports quarterly

- participate in Learning Collaborative
- share lessons learned

**Contact:** Cynthia.Mattingley@rmhp.org

### Rocky Mountain Health Plans PCMH Recognition

**Focus:** Practices will review and improve current processes and develop and implement new processes to build and maintain an infrastructure that supports ongoing improvement for the delivery of effective and efficient primary care, as recognized by and in accordance with NCQA's requirements of 2014 standards for PCMH Recognition. It is the goal to attain Level 3 Recognition from NCQA.

**Offered by:** Rocky Mountain Health Plans

**Funded by:** Rocky Mountain Health Plans

**Availability:** Available to approximately 10-15 RMHP primary care practices on the Western Slope. Transformation Team reviews and evaluates applications against program rubric. RMHP supports practices in their prep work for a Level 2 or 3 Recognition. Starts twice a year, January or July. Application submission timeframes are May and June for a July start.

**Practice Incentives:** \$10,000 compensation based upon submission of NCQA's Level 3 Recognition. CME's available (AMA PRA Category 1 CMEs for Learning Collaboratives and 20 Performance Improvement CMEs). MOC's available.

**Practice Commitments:** Create a practice quality-improvement team that meets at least twice a month with Quality Improvement Advisor to submit online application and purchase the required tools, complete software training for survey tool and participate in NCQA webinars, complete the PCMH gap analysis tool to determine needs, action items, responsible team members, and timelines, perform focused work on all.

**Contact:** Cynthia.Mattingley@rmhp.org

### Transforming Clinical Practice Initiative (TCPI)

**Focus:** This program is an opportunity for grant-funded in-office facilitation to prepare for evolving payment models that will compensate for demonstrated improvement in cost, quality and patient experience. A focus on measurably improving care delivery for both primary care and specialty care, with an emphasis on building strong referral relationships while also reducing cost and improving quality and patient experience of care.

**Offered by:** CHES partner organizations

**Funded by:** Center for Medicare and Medicaid Innovation

**Availability:** Program has the capacity to support 2000

clinics over 4 years (all in one cohort). There must be evidence of leadership commitment to allocating time to transformation activities, completed assessment. EMR capacity to submit quality measures, share data with peers, identify gaps in care, assign patients to provider panels. Anticipated start date: Fall 2015.

**Practice Incentives:** Credit towards Maintenance of Certification. Potential MOC available.

**Practice Commitments:** Two to three hours a month working with a practice facilitator initially, tapering off in subsequent years. Additional time as required to progress through TCPI phases of transformation. Submit measures. Participate in 2 regional learning sessions per year. Assign one provider and at least one staff member to be TCPI practice “champions.” Champions will be the primary contacts for TCPI-related activities and deliverables. They will attend 2 regional learning sessions per year.

**Contact:** [allyson.gottzman@ucdenver.edu](mailto:allyson.gottzman@ucdenver.edu)



category 3

## TEMPLATE OF THE FUTURE: INTEGRATION

*Maximizing the effectiveness of specialized resources typically found outside the practice (Behavioral Health as an example) through integration (workflow development, financing, outcomes analysis to document value).*

10

Template of  
the future:  
Integration

# INTEGRATION

## *Why would a practice be interested in integration ?*

Today, fully integrated care represents state of the art health care delivery that recognizes the significant impact on costs, quality of life, outcomes, and quality of career (providers) opportunities that exist with the effective alignment of important key resources such as behavioral health. This capstone endeavor and the related offerings will challenge practices to deliver care demonstrative of a significant change in the existing delivery system—change that results in measurable value to consumers, payers and providers.

### **BC3 Collective Impact**

**Focus:** Transitions of Care, Reductions in Avoidable ER Utilization, Facilitating Integrated and Coordinated Primary Care. Collaborative statewide initiative with multiple partners to focus on accelerating the Triple Aim: improving quality, reducing cost, and improving the patient experience.

**Offered by:** HealthTeamWorks

**Funded by:** The Colorado Health Foundation

**Availability:** Open to primary care practices. Cohort 1: Date: May 2015 with option to add practices through “open enrollment.” Cohort 2: Spring of 2016.

**Practice Incentives:** None specified

**Practice Commitments:** Quality measures: 4 adult and 2 pediatric. Milestone focus on priority areas of transitions of care, reduction in Emergency Room Utilization and facilitating integrated and coordinated primary care. There are 2 learning sessions per year. Time commitment dependent on choice of active coaching. Two meetings per month with coach, measures submitted monthly, 2 learning sessions per year. Community learning support, less intense practice support; more customized good fit for systems for a customized approach for their practices.

**Contact:** kmartina@healthteamworks.org

### **Chronic Condition Improvement Initiative**

**Focus:** Diabetes, Cardiovascular Prevention, Well-child, Immunizations, Pediatric Asthma, Pediatric Obesity, Access.

**Offered by:** Physician Health Partners

**Funded by:**

**Availability:** Available to all PHP IPA clinics. Ongoing relationship with all physician practices. Physician must be a member of one of the IPAs supported by PHP. Primary

Care Only. Primary Care Physicians can join IPAs at any time. Open enrollment.

**Practice Incentives:** CMEs available; MOCs available.

**Practice Commitments:** Practice must meet IPA goals and requirements. Practice has an ongoing relationship with QI Coach; ideally meets with Coach at least monthly and works on QI initiatives throughout the month. Each IPA has specified round tables and educational opportunities from monthly to annually.

**Contact:** Katy.burlingame@phpmcs.com or Zula.Solomon@phpmcs.com.

### **Colorado Children’s Health Access Program (CCHAP)—Integrated Behavioral Health In Medical Homes (Primary Care Practices) for Children in Colorado**

**Focus:** CCHAP’s child psychologist provides coaching for practices and training for integrated behavioral health providers interested in integrating behavioral health for children into their practices. We provide training and learning communities practices and for integrated behavioral health providers. For practices and clinics without an integrated behavioral health provider, we provide coaching regarding behavioral health screening at well visits, effective referrals, and care coordination. Also CCHAP coaches practices regarding billing, coding, reimbursement and maximizing sustainability.

**Offered by:** CCHAP

**Funded by:** Four Colorado Foundations

**Availability:** Will provide coaching on screening, intervention and referral for 255 practices and clinics interested in behavioral health for children. Rolling entrance into the program.

**Practice Incentives:** None specified

**Practice Commitments:** For Integrated Behavioral Health training: 2-3 day training for behavioral health provider, physician champion, practice managers. Followed by monthly learning collaborative. For BH screening: one coaching visit to practice plus ongoing telephone support. Integrated Behavioral Health: Only requirement is an interest in developing integrated behavioral health. 2-3 day training for behavioral health providers and anyone else from the practice who is interested. Ongoing learning community on monthly basis. Telephone consultation at any time. Practice moves at its own pace. BH screening program: Can provide training in-practice, by sending a manual or by phone. Access to newsletters, webinars as well. No specific requirements for practice.

**Contact:** CCHAP, Patrece.hairston@childrenscolorado.org

### Colorado Community Health Alliance— Practice Transformation: Integration

**Focus:** Colorado Community Health Alliance is committed to helping practices build sustainable processes to deliver comprehensive, patient-centered care through the promotion of care coordination and team-based care and extensive support for the integration of behavioral health practice into the primary care setting.

**Through Practice Transformation:** Integration, Colorado Community Health Alliance will utilize its expertise in this area to:

- Promote coordination of care with specialists, community resources (including provision of Colorado Community Health Alliance care coordinators)
- Assess practice readiness for behavioral health integration
- Support the practice with tools and best practices for implementation of
  - Routine behavioral health screenings and behavioral health treatment referral processes/coordination of care
  - Behavioral health co-location
  - Behavioral health embedment

**Offered by:** Colorado Community Health Alliance (RCCO 6)

**Funded by:** Colorado Community Health Alliance (RCCO 6)

**Availability:** Available to all practices contracted with Colorado Community Health Alliance (RCCO 6); eligibility criteria may apply.

**Practice Incentives:** None specified

**Practice Commitments:** Practice must work on Key Performance Indicators established by the Colorado Medicaid ACC Program. Practice has established quality

improvement and process improvement practices. Practice is committed to team-based, patient-centered care. Practice engages in services provided by the Colorado Community Health Alliance care coordination team. Practice commits to completing a Behavioral Health Readiness Assessment and displays willingness to progress in behavioral health integration.

**Contact:** Meg Taylor, meg.taylor@phpmcs.com

Zula Solomon, Zula.Solomon@phpmcs.com

### Colorado Community Health Network (CCHN) Advanced Clinical Transformation

**Focus:** Advanced Clinical Transformation: Focus on PCMH recognition, practice transformation, BH and oral health integration, innovative technology, care coordination, data for quality improvement, social determinants of health, KP ALL program, and patient experience

**Offered by:** Colorado Community Health Network (CCHN)

**Funded by:** Kaiser Permanente and The Colorado Health Foundation

**Availability:** Open to FQHC or look-alike and primary care CHCs. 2015—June—phase 1.  
2016—October—end of phase 2.

**Practice Incentives:** Travel reimbursement to CCHN learning sessions (same for all of the initiatives except for team-based care).

**Practice Commitments:** One annual Learning session. Measures align with UDS and submitted quarterly to CCHN. Practice facilitator monthly meeting by phone or F2F. Monthly webinars.

**Contact:** jessica@cchn.org

### Colorado Community Health Network Oral Health Integration and Transformation

**Focus:** Providing baseline assessment and practice coaching in oral health integration

**Offered by:** Colorado Community Health Network (CCHN)

**Funded by:** Delta Dental

**Availability:** Open to 5 FQHC sites.

**Practice Incentives:** Travel reimbursement to CCHN learning sessions.

**Practice Commitments:** One annual learning session.

**Contact:** Jessica@cchn.org

## Colorado State Innovation Model (SIM)

**Focus:** A focus on facilitating the evolution to comprehensive primary care models that include behavioral health integration. The SIM program includes practice transformation support, payment reform, regulatory reform, and consumer and community engagement.

**Offered by:** CCPT partners

**Funded by:** Center for Medicare and Medicaid Innovation

**Availability:** Open to practices with leadership commitment to practice transformation that includes advancing along the spectrum of behavioral health integration. Other criteria have not been determined. EMR capacity that includes the ability to report quality measures, identify gaps in care, assign patients to provider panels. The application process will begin in the Fall of 2015. Practice notifications expected December 2015. SIM will support the following number of practices:

- 2016—100 primary care practice sites
- 2017—150 primary care practice sites
- 2018—150 primary care practice sites

Time frame:

- Cohort 1: Feb 2016–Jan 2018
- Cohort 2: Feb 2017–Jan 2019
- Cohort 3: Feb 2018–Jan 2019

**Practice Incentives:** Up to \$5000 from SIM Transformation fund—plus opportunity to apply for additional funds based on need and/or innovation No information regarding payer compensation at this time.

**Practice Commitments:** Allocate time to work with a practice facilitator; approximately 2 to 3 hours a month to achieve SIM program milestones (refer to website for specifics) Practices commit to:

Improve access to and coordination with behavioral health services for their patients. Work with SIM HIT/HIE support team to collect, review and report a core set of clinical quality measures. (See website for specific measures.)

Assign one provider and at least one staff member to be SIM practice “champions.” Champions will attend two regional learning sessions per year.

**Contact:** Simpracticeinfo@ucdenver.edu. For detailed information about the measures and milestones refer to [www.SIMpracticeinformation.gov](http://www.SIMpracticeinformation.gov). To apply: [www.SIMapplication.gov](http://www.SIMapplication.gov). Details of the selection process and webinars available after September 15, 2015.

## iPN Quality Improvement Program

**Focus:** Focus is on Diabetes, Cardiovascular Health, Behavioral Health integration, Prevention, Hospital Utilization, Patient Experience, Patient Centered Medical Home, Meaningful Use, PQRS, CPC, and other CMS programs.

**Offered by:** integrated Physician Network

**Funded by:** Centura/independent practice members

**Availability:** All iPN member practices who participate in single-signature contracting will receive practice transformation support.

**Practice Incentives:** Currently limited to minimal compensation provided for practice staff time to participate in certain quality initiatives.

**Practice Commitments:** Practice must demonstrate engagement in iPN quality efforts including regularly meeting with an iPN coach, forming a QI team, setting aims and identifying PDSAs, reviewing and validating data from multiple sources, and publicly sharing QI work with the iPN general membership (at least annually). Practice representatives must attend regular monthly practice leadership meetings and quarterly general membership meetings.

**Contact:** Tessa C Arons, Director of Quality [tessaarons@centura.org](mailto:tessaarons@centura.org)

## Physician Health Partners—Practice Transformation: Integration

**Focus:** Physician Health Partners is committed to helping practices build sustainable processes to deliver comprehensive, patient-centered care through the promotion of care coordination and team-based care and extensive support for the integration of behavioral health practice into the primary care setting.

Through Practice Transformation: Integration, Physician Health Partners will utilize its expertise in this area to:

- Promote coordination of care with specialists, community resources (including provision of Physician Health Partners care coordinators)
- Assess practice readiness for behavioral health integration
- Support the practice with tools and best practices for implementation of:
  - Routine behavioral health screenings and behavioral health treatment referral processes/coordination of care

- Behavioral health co-location
- Behavioral health embedment

**Offered by:** Physician Health Partners

**Funded by:** Physician Health Partners

**Availability:** Available to all primary care practices that are members of one of the Independent Practice Associations (IPA) supported by Physician Health Partners; IPA membership is open to eligible primary care providers upon request.

**Practice Incentives:** None specified

**Practice Commitments:** Practice must meet Physician Health Partners IPA goals and requirements. Practice has established quality improvement and process improvement practices. Practice is committed to team-based, patient-centered care. Practice engages in services provided by the Physician Health Partners care coordination team. Practice commits to completing a Behavioral Health Readiness Assessment and displays willingness to progress in behavioral health integration.

**Contact:** Zula Solomon, zula.solomon@phpmcs.com;  
Meg Taylor, meg.taylor@phpmcs.com



## ADDITIONAL OFFERINGS

*These are variable, specialized consulting type services available to practices, typically with a fee.*



### Centura Health Physician Group (CHPG) PCMH Recognition

**Focus:** Performance improvements, standard work and the Patient Centered Medical Home model are used to drive effective and efficient evidenced-based care.

**Offered by:** Centura Health Physicians Group

**Funded by:** Centura Health

**Availability:** Open to practices within the Centura Health Physicians Group network.

**Practice Incentives:** Performance-based (annually)

**Practice Commitments:** Monthly review of data, implementation of performance improvement opportunities.

**Contact:** christinelewis@centura.org, 303-643-0955

### ClinicNET State Association for Community Safety Net Clinics

**Focus:** Strengthening safety net clinics through on-site assessments, analysis and coaching for increased efficiencies and/or alignment with current initiatives.

**Offered by:** ClinicNet

**Funded by:** Local foundations

**Availability:** Open to safety net clinics that do not refuse patients solely based upon ability to pay and provide any scope of service or combination of services, i.e., primary care, mental health and substance abuse treatment, dental, optical or any specialty care, and they are a free clinic, or offer a sliding fee scale or a flat fee; and the clinic's patient mix must include low-income uninsured, underinsured or publicly insured patients.

**Practice Incentives:** None specified

**Practice Commitments:** Variable: direct support services and education including in-clinic and out-of-clinic quality-improvement coaching, educational webinars, blogs, collaborative and networking opportunities and providing resources and tools to meet the needs of our affiliate clinics. Participation fee depending on services needed.

**Contact:** For Affiliation: brooke.powers@clinicnet.org, 720-863-7803. For Quality Improvement services: cathryn.benedict@clinicnet.org, 720-280-0997

### Colorado Rural Health Center Health Awareness for Rural Communities DataBank (HARC)

**Focus:** Focus on assisting rural communities and facilities with population health statistics to inform quality and strategic initiatives.

**Offered by:** Colorado Rural Health Center

**Funded by:**

**Availability:** Available to all rural practices.

**Practice Incentives:** None specified

**Practice Commitments:** Practice commitments depend on service requested. Some services free; other fees vary by service needs.

**Contact:** Melissa Bosworth, Director of Workforce and Outreach, mb@coruralhealth.org, www.coruralhealth.org

### Colorado Rural Health Center Outreach Program

**Focus:** Focus on creating promotional material and awareness for rural facilities and communities utilizing facility-level statistics and population statistics.

**Offered by:** Colorado Rural Health Center

**Funded by:**

**Availability:** Available to all rural practices.

**Practice Incentives:** None specified

**Practice Commitments:** Practice commitments depend on service requested. Some services free; other fees vary by service needs.

**Contact:** Melissa Bosworth, Director of Workforce and Outreach, mb@coruralhealth.org, www.coruralhealth.org

### Connection to HIE—Front Range

**Focus:** Connection to HIE

**Offered by:** Colorado Regional Health Information Exchange (CORHIO)

**Funded by:**

**Availability:** Open to all

**Practice Incentives:** None specified

**Practice Commitments:** Varies

**Contact:** Drew Currie, DCurrie@Corhio.org

## Connection to HIE—Western Slope

**Focus:** Connection to HIE/EHR interface/Alerts/Subscription/Image enabled results delivery/Single Sign On (SSO)/Direct messaging/Electronic ordering/ Delivery of CCD or CCD-A/Care Coordination.

**Offered by:** Quality Health Network (QHN)

**Funded by:**

**Availability:** open to all

**Practice Incentives:** None specified

**Practice Commitments:** varies

**Contact:** support@qualityhealthnetwork.org

## CORHIO Consulting Services

**Focus:** Experienced staff provide a full spectrum of quality improvement services to various practice types ranging from specialty to general care, from small to large. In particular, CORHIO transformation support staff has extensive experience assisting with Meaningful Use, PQRS, Value Based Payment Modifier, Clinical Quality Measures, NCQA PCMH and assisting with meeting Privacy and Security standards.

**Offered by:** CORHIO

**Funded by:**

**Availability:** Any practice seeking to improve patient care through quality measures.

**Practice Incentives:** None specified

**Practice Commitments:**

**Contact:** Kelly Procopio, Transformation Support Services Director, kprocopio@corhio.org, 720-285-3251

## Healthy Clinic Assessment Program

**Focus:** Focus on technical assistance to enhance efficiencies by improving basic business operations and processes.

**Offered by:** Colorado Rural Health Center

**Funded by:**

**Availability:** Open to all rural practices.

**Practice Incentives:** None specified

**Practice Commitments:** Participation in one-day assessment process.

**Contact:** www.coruralhealth.org

## NCQA Consulting Support Services

**Focus:** NCQA multi-site and individual practice gap assessments. NCQA multi-site and individual practice application support from an NCQA Certified Content Expert (CCE) that can include webinars on standards for use of system/practices, documentation templates for NCQA submission materials, document review and submission support, direct project management and material development services.

**Offered by:** HealthTeamWorks

**Funded by:**

**Availability:** Available to primary care practices and systems.

**Practice Incentives:** None specified

**Practice Commitments:** Flat fee for assessment. Contract, based on level of support negotiated with the client.

**Contact:** ebuscaj@healthteamworks.org



# PRACTICE TRANSFORMATION ORGANIZATIONS

*These practice transformation organizations provide support services to medical practices. This support includes practice facilitation, health IT and health information exchange support, change management and quality-improvement activities.*

## CLINICNET

ClinicNET is committed to supporting community-supported safety net clinics to advance care delivery while staying true to core values. We accomplish this with personalized coaching, use of the Healthy Clinic Assessment, making available collaborative and networking opportunities and sharing resources and tools. We are a membership organization enabling us to understand community-supported safety net clinics and better meet their needs. ClinicNET's consulting services offer over 25 years of operational experience within medical, dental and mental health facilities. A few examples include increasing workflow efficiency, weaving together silos of work tasks, strengthening fragmented schedules, aligning with current initiatives, increasing accountability, utilizing technologies to their fullest.

## CENTURA HEALTH PHYSICIAN GROUP

The Centura Health Physician Group is a network of nearly 500 medical providers in more than 100 locations across Colorado and western Kansas.

## COLORADO CHILDREN'S HEALTHCARE ACCESS PROGRAM

The Colorado Children's Healthcare Access Program (CCHAP) is devoted to assisting practices and clinics statewide to provide comprehensive, cost-effective, coordinated, quality health care for all children in Colorado. CCHAP has 10 years of experience in all aspects of practice transformation, practice management, quality improvement, integration of behavioral health, population health, using data to improve health outcomes, and the implementation of care coordination in pediatric and family practices and clinics statewide. CCHAP has developed learning communities for care coordination and integrated behavioral health for children. Find us at [cchap.org](http://cchap.org).

## COLORADO COMMUNITY HEALTH ALLIANCE

Colorado Community Health Alliance (CCHA) is here to help our contracted practices succeed as part of the Medicaid Accountable Care Collaborative (ACC) Program and develop medical homes for Medicaid members in Region 6—Boulder, Broomfield, Jefferson, Clear Creek, Gilpin County. CCHA currently supports 114,000 patients and 700 primary care providers. Our goal is to bring quality care to the Medicaid population in Region 6 while helping control the costs of care for Colorado. CCHA offers various resources to help connect and engage both patients and providers in the health care process. We strive daily to achieve the Triple Aim of improving population health, enhancing patient experience with care received, and reducing or controlling the per capita cost of care.

## COLORADO COMMUNITY HEALTH NETWORK

The Colorado Community Health Network (CCHN) is the unified voice for Colorado's 19 Community Health Centers (CHCs) and their patients. CHCs provide a health care home to more than 650,000 of their community members— one in eight people in Colorado— from 60 of the state's 64 counties. Without CHCs, hundreds of thousands of Colorado's low-income families and individuals would have no regular source of health care. CCHN's mission is to increase access to high-quality health care for people in need in Colorado. For more information about CCHN, please visit [www.cchn.org](http://www.cchn.org).

## COLORADO HEALTH NEIGHBORHOOD

Colorado Health Neighborhoods (CHN) is a network of more than 2,800 independent and employed physicians, along with other health professionals, dedicated to developing a clinically integrated network that delivers optimal health care value to consumers. CHN is creating a system that promotes proactive coordination among providers to produce demonstrably improved health outcomes at an affordable cost in a more convenient, service-oriented setting. Leveraging a partnership with Centura Health, the region's largest health care leader, CHN has the resources to deliver on its vision for the future of health care. For more information, visit [www.coloradohealthneighborhoods.org](http://www.coloradohealthneighborhoods.org).

## COLORADO RURAL HEALTH CENTER

The Colorado Rural Health Center (CRHC) is Colorado's nonprofit State Office of Rural Health. CRHC works with federal, state and local partners to offer services and resources to rural healthcare providers, facilities and communities. We have a diverse and inclusive statewide constituency of over 3,500 people and organizations. Our mission is to enhance healthcare services in the state by providing information, education, linkages, tools, and energy toward addressing rural health issues. Our vision is to improve healthcare services available in rural communities to ensure that all rural Coloradans have access to comprehensive, affordable, high-quality healthcare.

## CORHIO

CORHIO is a Colorado-based nonprofit organization working in partnership with thousands of healthcare providers to revolutionize the way medical professionals use digital health records. CORHIO's advanced health information exchange (HIE) technology provides instant access to information that saves lives, streamlines care coordination, reduces costs, and improves clinical outcomes for millions of people. Through its Transformation Support Services group, CORHIO provides services to physician offices, medical clinics and small hospitals that need assistance with electronic health record (EHR) system selection and adoption, EHR Incentive Programs and Meaningful Use, medical home recognition and clinical quality reporting. For more information, visit [www.corhio.org](http://www.corhio.org).

## DENVER HEALTH AND HOSPITAL AUTHORITY

Denver Health and Hospital Authority (DHHA) is an integrated delivery service system serving the city and county of Denver since 1860. The DHHA community health system collaboration consists of a primary care network of "medical homes" situated within a larger "medical neighborhood" connected organizationally and virtually. Denver Health's Community Health Services (CHS) is the second oldest and largest community health center program in the United States. In its 49-year history, CHS has expanded into a network of eight community health centers, two urgent care centers and 16 school-based health clinics serving one of five residents in the City and County of Denver. CHS served more than 130,000 individuals in 2014.

## HEALTHTEAMWORKS®

HealthTeamWorks® is a nonprofit, multi-stakeholder collaborative working to redesign the healthcare delivery system and promote integrated communities of care, using evidence-based medicine and innovative systems. Our goals are to optimize health, improve quality and safety, reduce costs and improve the care experience for patients and their healthcare teams.

## HIGH PLAINS RESEARCH NETWORK

Established in 1997, the HPRN is an integrated network of the primary care practices and communities in the sixteen counties of eastern rural Colorado. HPRN conducts practice transformation and research that links primary care, public health, and community organizations to build local communities of solution. HPRN engages community members, patients and providers to translate the best evidence-based science into locally relevant, actionable programs and projects. HPRN applies mixed methods to generate comprehensive local needs assessments and to support strategic planning. The network staff is based in the Department of Family Medicine at the University of Colorado Denver School of Medicine.

## INTEGRATED PHYSICIAN NETWORK

iPN is a physician led IPA (Independent Physician Association) with 275 providers across 20 practices primarily located in and around the Denver metro area. Our mission is to improve the health of our patients by creating a sustainable, clinically integrated network of independent primary care, specialty care, and hospital service providers. Using a common electronic medical record, an evidence-based quality improvement program and primary source data, community providers will deliver safer, more efficient and more effective care, across the continuum of care, and demonstrate the value their service brings to their patients and healthcare system. In addition, iPN's vision is to promote the workplace vitality for physicians, providers, and their healthcare teams.

## JOHN SNOW INC. (JSI)

The JSI Denver Office has been in operation since 1980. JSI is a public health research and consulting organization committed to improving the health of individuals and communities, with a focus on vulnerable and underserved populations. JSI staff have extensive experience assisting primary care practices in transforming to respond to changes at the local, state and national level. Our knowledge and experience of models for success include team-based care, behavioral and oral health integration into primary care, payment reform, medical and neighborhood homes, accountable care organizations, and Lean among others. We take pride in our ability to engage, mobilize, and build capacity in diverse stakeholder groups to achieve common goals.

## PHYSICIAN HEALTH PARTNERS

Denver-based Physician Health Partners (PHP) is an integrated team of physicians and health care professionals committed to supporting effective patient care throughout the health care continuum. Founded in 1996, PHP collaborates with more than 300 primary care providers, both physicians and mid-level providers, and approximately 600 specialists in the Denver metro area who share the goal of providing the right care, at the right time and in the right setting. Because we were formed and are still led by physicians, we strive to support and enhance the primary care physician's role in coordinating care for over 340,000 patients. We provide innovative tools and programs to help drive quality outcomes and more cost-effective healthcare to their patients.

## QUALITY HEALTH NETWORK

Founded in 2004, Quality Health Network (QHN) is a not-for-profit community partnership dedicated to healthcare quality improvement. QHN serves the western region of Colorado by providing for the secure exchange of health information between authorized medical providers as a health information exchange (HIE). QHN offers a wide range of products and services designed to help healthcare and providers with health information technology adoption, practice transformation activities, and the innovative use of information for improved patient outcomes and cost savings for all. For more than a decade QHN has been recognized as one of the nation's leaders in HIE. For more information about QHN, please visit [www.qualityhealthnetwork.org](http://www.qualityhealthnetwork.org).

## ROCKY MOUNTAIN HEALTH PLANS— PRACTICE TRANSFORMATION TEAM

The Practice Transformation Team at Rocky Mountain Health Plans (RMHP) is an integral part of the Clinical Program Development and Evaluation Department. The team works, in alignment with RMHPs Mission and Values, to develop a community of advanced primary care practices that work efficiently and collaboratively within the medical neighborhood. Their efforts align with other efforts within the health plan and the communities served by RMHP to facilitate the ongoing improvement that addresses each of the six IOM aims (Care that is safe, effective, timely, efficient, patient-centered, and equitable). The team works to develop and deploy support programs, tools and resources, and training and coaching to assist practices wishing to advance their capacity to provide comprehensive primary care.

## SCL HEALTH PSO, LLC

SCL Health PSO LLC is a wholly owned entity within SCL Health. We work diligently to stay at the forefront of the health care industry, leading our peers in pursuing new and better ways of providing quality, person-centered health care. SCL Health and our Care Sites aspire to lead the health care industry in delivering compassionate, quality care effectively and strategically.

## TELLIGEN QUALITY INNOVATION NETWORK—QUALITY IMPROVEMENT ORGANIZATION

The Telligen QIN-QIO, in collaboration with CMS, supports the National Quality Strategy of better care, better health for people and communities and affordable care through improvements. Teams work side-by-side with providers in all settings of care on quality-improvement initiatives, while pooling resources and common elements to best serve beneficiaries, families, caregivers and providers.

**Our Approach:** We provide communities with technical assistance, convening learning and action networks for sharing best practices, and collecting and analyzing data for improvement. We align statewide partners and ongoing initiatives to create efficiencies and maximize momentum.

## UNIVERSITY OF COLORADO COLLEGES OF NURSING

The University of Colorado is home to two Colleges of Nursing—the University of Colorado Anschutz Medical Campus College of Nursing and the University of Colorado Colorado Springs Beth El College of Nursing and Health Sciences. They offer an expert faculty consulting team that provides practice improvement support for independent nurse practitioner-led clinical practices. Consultation services include practice management, health information systems, business management, managed care, quality improvement, care coordination, team care models, and process improvement utilizing rapid methods. Faculty consultants provide nurse practitioners nationally recognized support for improvement in practice management resulting in improved delivery of health services.

## UNIVERSITY OF COLORADO HEALTH

University of Colorado Health is a Front Range health system that delivers the highest quality patient care with the highest quality patient experience. University of Colorado Health combines Memorial Hospital, Poudre Valley Hospital, Medical Center of the Rockies, Colorado Health Medical Group, and University of Colorado Hospital into an organization dedicated to health and providing unmatched patient care in the Rocky Mountain West. UCHealth partners with the University Of Colorado School Of Medicine and numerous community organizations to provide care. Separately, these institutions can continue providing superior care to patients and service to the communities they serve. Together, they push the boundaries of medicine, attracting more research funding, hosting more clinical trials and improving health through innovation.



# GLOSSARY

## Terms and Definitions

### **Accountable Care Collaborative (ACC)**

Colorado's Medicaid primary health care program designed to improve health and help patients access the services needed to stay healthy. The ACC model is based on clinicians sharing information across the continuum to coordinate care, applying evidence-based medicine, manage patient populations, and collaborate to align incentives while patients are encouraged to take an active role in their own care.

**Accountable Care Organization (ACO)** A health care organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, receive the right care, at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

**Affordable Care Act (ACA)** ACA is used to refer collectively to two pieces of legislation—the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). The ACA was enacted to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of health care for individuals and the government.

**Behavioral Health** Behavioral health encompasses behavioral factors in chronic illness care, care of physical symptoms associated with stress rather than diseases, and health behaviors, as well as mental health and substance abuse conditions and diagnoses.

**Behavioral Health Organization (BHO)** An organization that arranges for a member to get medically necessary behavioral health services. The community behavioral health services program in Colorado is statewide and provides mental health and substance use disorder services to all Colorado Medicaid members. Each Medicaid member is assigned to a BHO based on where they live.

**Behavioral Health Provider (BHP)** A mental health or substance abuse treatment provider such as a psychiatrist, social worker, psychologist, licensed chemical dependency counselor or psychiatric nurse.

**Bi-directional Integration** Addressing the need for primary care services in behavioral health settings as well as the need for behavioral health services in primary care settings.

**Care Coordination** Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the arranging of resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

**Care Management** A set of evidence-based integrated care practices in which patients are educated about their behavioral health and/or physical health and

regularly monitored for their response and adherence to treatment.

**Clinical Health Information Technology Advisor (CHITA)** An expert in data capture and data reporting. The CHITA becomes familiar with the electronic health record (EHR) platform in each practice to understand how best to report clinical data that document measures that matter to the practice. The CHITA supports practice workflow as it relates to effective data capture in the EHR, provides oversight and analysis of consistent data entry across practices to enhance the ability to accurately measure and report on key metrics. The CHITA and the practice facilitator/coach work together closely to optimize their respective skills for the benefit of the practice.

**Co-location or Colocation** An integrated health care approach in which both physical and mental health providers are located in the same building or on the same premises to increase access to those services and to reduce the stigma of seeking mental health treatment.

**Colorado Health Extension Service (CHES)** A collaborative, multi-stakeholder organization that seeks to improve health and health care across Colorado through: 1) supporting redesign and innovation in primary care practices, improving their readiness for new payment models through practice transformation support and infrastructure development; 2) promoting local collaboration among health care providers, community groups, patient advisory groups, local public health officers, and public health agencies; and 3) facilitating local or regional efforts to improve health care to meet the Triple Aim of improving quality, improving experience of health care, and reducing costs.

**Colorado Regional Health Information Organization (CORHIO)** A nonprofit organization that provides secure health information exchange (HIE) services, as well as the convener of the Colorado Regional Extension Center (REC) to support the meaningful

use and adoption of EHRs. CORHIO operates as one of two HIEs for the state of Colorado.

**Community Health Center (CHC)** See Federally Qualified Health Center (FQHC) definition.

**Comorbidity** The co-existence of two or more illnesses at the same time.

**Coordinated Care** Integrating the efforts of medical, behavioral health, and social service providers while addressing an individual's health and wellness.

**Federally Qualified Health Center (FQHC)** Organizations that receive grants, or qualify to receive grants (FQHC look-alikes), under Section 330 of the Public Health Service Act (PHS). FQHCs qualify for specific reimbursement systems from Medicare and Medicaid, as well as other benefits. FQHCs must offer services to all persons, regardless of ability to pay, serve an underserved area or population, offer a sliding fee scale, provide comprehensive primary care services, have an ongoing quality assurance program, and have a governing board of directors that is made up of at least 51 percent consumers. In Colorado, the terms FQHC and Community Health Center (CHC) are often used interchangeably.

**Federally Qualified Health Center (FQHC) Look-Alikes** FQHC look-alikes are certified by the federal government as meeting all the Health Center Program requirements, but do not yet receive funding under the Health Center Program.

**Health Information Exchange (HIE)** A system that allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically.

**Health Information Technology (HIT)** The umbrella framework to describe the comprehensive management of health information across

computerized systems and its secure exchange between consumers, providers, government and quality entities, and insurers.

**Health Information Technology for Economic and Clinical Health (HITECH) Act** The HITECH Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology.

**Institute for Healthcare Improvement (IHI)** An independent nonprofit organization that is a leading innovator, convener, partner, and driver of health care improvement worldwide. They developed the Triple Aim—a framework within which a health system’s performance is optimized.

**Integrated Healthcare** The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

**Integrated Practice Assessment Tool (IPAT)** A tool that uses a decision tree to determine the readiness of a practice to enter into collaboration/integration. The tool rates a practice on a scale of 1 (pre-coordinated care) to 6 (fully integrated care).

**Learning Collaborative** A group of practice teams who collectively agree to work together to achieve a specific aim for the group as a whole. In order to reach the aim, all members of the collaborative gather in “learning sessions” to share what has worked and not worked. Sometimes, *Learning Collaborative* is used to refer to the gathering of practice teams to engage in peer-to-peer learning and sharing.

**Learning Session** An identified meeting or period of time dedicated to a particular activity aimed at convening members of a group who share what has worked and not worked related to achieving a specific aim.

**Meaningful Use (MU)** The measureable benchmarks providers must meet to qualify for incentive payments under the Health Information Technology for Economic and Clinical Health (HITECH) Act.

**Mental Health** A state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

**Mental Illnesses** Refers to disorders generally characterized by dysregulation of mood, thought, and/or behavior, as recognized by the Diagnostic and Statistical Manual (DSM-currently 5th edition) of the American Psychiatric Association.

**Patient-Centered Medical Home (PCMH):** According to the American College of Physicians (ACP) a Patient-Centered Medical Home is a team-based model of care led by a personal physician who provides comprehensive, continuous and coordinated care throughout a patient’s lifetime to maximize health outcomes.

**Patient Registry** A log or database of all patients in a clinic or practice who have a particular illness or condition.

**Practice Facilitator/Quality Improvement Advisor/Quality Improvement Coach/Quality Improvement Specialist** A person who works with practice teams to facilitate practice change that includes many aspects of care delivery: team-based care, population management, care coordination and care management, patient engagement, building medical neighborhoods, and others. These terms are often used interchangeably in Colorado.

**Practice Support** Practice facilitators provide support in the areas of HIT/HIE, medical home transformation, help with business processes, quality-improvement initiatives. Practice support varies significantly in pace, intensity, duration, and content.

**Practice Transformation** Substantive change in how care is delivered in preparation for substantive change in how care is compensated. Evolving payment models will be based on demonstrated value of care, not activities of care. These changes include evolving to a model of proactive, planned care, as opposed to episodic, reactive care; using registry functionality to identify gaps in care, outreach to patients to address gaps in care; using data to improve processes of care; and developing patient panels assigned to practice care teams to enhance continuity of care. Other changes may include new roles and responsibilities, different workflows, and new positions within the practice such as care managers or behavioral health professionals.

**Practice Transformation Organization (PTO)** An organization that provides support services to medical practices in the area of practice facilitation, HIT/HIE support, change management, and quality-improvement activities.

**Primary Care** The basic, entry-level health care provided by physicians or non-physician health care practitioners that is generally provided in an outpatient setting.

“Comprehensive primary care”, at a minimum, includes providing or arranging for the provision of the following services on a year-round basis: Primary health care; maternity care, including prenatal care; preventive, developmental, and diagnostic services for infants and children; adult preventive services, diagnostic laboratory and radiology services; emergency care for minor trauma; pharmaceutical services; and coordination and follow-up for hospital care.

*Based on Comprehensive Primary Care definition from*

*Colorado Indigent Care Program (CICP) from 25.5-3-203 (1) C.R.S.*

**Primary Care Medical Provider (PCMP)** PCMPs are doctors, nurse practitioners, and physician assistants that act as the “medical home” to patients participating in the Colorado ACC.

**Quality Health Network (QHN)** A quality improvement organization that provides secure electronic health information exchange (HIE) services to support the meaningful use and adoption of EHRs. QHN operates as one of two HIEs for the state of Colorado, with its focus on the Western Slope.

**Quality Improvement (QI)** QI consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

**Quality Improvement Initiative** Process improvement projects for a defined, limited scope objective; for example, breast cancer screening.

**Regional Care Collaborative Organization (RCCO)** An organization that provides coordinated care for Colorado Medicaid clients by connecting them with PCMPs and other community-based services.

**Regional Health Connector (RHC)** *previously referred to as Health Extension Agent:* A person who provides an essential connector function among health-related organizations in the region to promote improvement of the health of the community; builds ongoing supportive relationships with primary care practices including assessing practice needs and connecting the practice to appropriate resources that may include practice facilitation, HIT support, local public health agencies, and community resources to support patients.

**State Innovation Model (SIM)** A nationwide effort to build an innovative and integrated system of health

care services. Colorado is one of a number of states to receive SIM funding. The initial award of \$2 million in 2013 supported preliminary efforts to develop a system of physical and behavioral health integration. In December 2014, the State was awarded \$64 million over four years to “create a coordinated, accountable system of care that gives Coloradans access to integrated primary care and behavioral health.”

**Triple Aim** A framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. It is IHI’s belief that new designs must be developed to simultaneously pursue three dimensions, which they call the “Triple Aim”: 1) improving the patient experience of care (including quality and satisfaction); 2) improving the health of populations; and 3) reducing the per capita cost of health care.

**Value-Based Payment** A strategy used by purchasers to promote a quality and value of health care services with the goal of shifting from volume-based payment to payments aligned with outcomes.

# APPENDIX:

## Comprehensive Primary Care Practice Monitor “Building Blocks” Version—8.9.15

In the tables below, consider how fully each item has been implemented or functions in your practice. Fill in the circle that best reflects the completeness of implementation in your practice. If something is completely implemented, it means it is now routine across the entire practice.

1. ENGAGED LEADERSHIP	NOT AT ALL ▼	COMPLETELY ▼
a. Practice leaders support innovation and are willing to take risks and tolerate occasional failures in order to improve.	①	① ② ③ ④
b. A culture of shared leadership has been created, with everyone sharing responsibility for change and improvement in the practice.	①	① ② ③ ④
c. The practice has a shared vision for practice transformation that everyone understands and supports.	①	① ② ③ ④
d. Practice leaders proactively remove organizational barriers to change and improvement.	①	① ② ③ ④
e. The concepts of the medical home are understood and actively supported by practice leaders.	①	① ② ③ ④
f. Effective business processes are being built to support new models of care and payment.	①	① ② ③ ④

2A. QI PROCESS	NOT AT ALL ▼	COMPLETELY ▼
a. There is a QI team that meets regularly (at least twice a month).	①	① ② ③ ④
b. QI team meetings are well-organized, with agendas, meeting summaries, prepared leaders and members.	①	① ② ③ ④
c. The QI team uses QI tools effectively—AIM statements, process mapping, PDSA.	①	① ② ③ ④
d. QI team members reliably follow-up on assignments and tasks, with good team accountability.	①	① ② ③ ④
e. The QI team has a sustainable, reflective QI process that deals effectively with challenges and conflict.	①	① ② ③ ④
f. Staff members are actively and regularly involved in QI team meetings.	①	① ② ③ ④

<b>2B. DATA DRIVEN IMPROVEMENT</b>	<b>NOT AT ALL</b> ▼	<b>COMPLETELY</b> ▼
a. Quality measures are reported and reviewed monthly.	①	② ③ ④
b. Clean and accurate quality measurement data are available for targeted conditions.	①	② ③ ④
c. We are able to extract data from our medical record systems for registries (lists of patients with particular conditions and with key information about those patients.)	①	② ③ ④
d. Workflows for maintaining accurate registry data have been reliably implemented.	①	② ③ ④
e. Quality measures and other data are used as a central area of focus for the practice's improvement activities.	①	② ③ ④

<b>3. EMPANELMENT</b>	<b>NOT AT ALL</b> ▼	<b>COMPLETELY</b> ▼
a. Our practice has an ongoing, reliable system for empanelment and panel management within our data systems and practice processes.	①	② ③ ④
b. Every patient is assigned a personal clinician, with a small team to serve as back-up when the personal clinician is unavailable.	①	② ③ ④
c. Patient panels are used as the foundation for population health management.	①	② ③ ④

<b>4. TEAM-BASED CARE</b>	<b>NOT AT ALL</b> ▼	<b>COMPLETELY</b> ▼
a. Care teams have been designated and have regular team meetings.	①	② ③ ④
b. Standardized protocols and standing orders have been created to maximize the efficiency of the practice workflow.	①	② ③ ④
c. Team members have defined roles that makes optimal use of their training and skill sets.	①	② ③ ④
d. Team huddles are used to discuss patient load for the day and to plan for patient visits.	①	② ③ ④

<b>5. PATIENT-TEAM PARTNERSHIP</b>	<b>NOT AT ALL</b> ▼	<b>COMPLETELY</b> ▼
a. A system has been implemented for including patient and family input in ongoing improvement activities (such as patient advisory groups or patients or family members on QI teams).	①	② ③ ④
b. A patient experience survey is used regularly (monthly or quarterly) to monitor practice performance.	①	② ③ ④
c. Care plans are regularly reviewed to monitor patient progress in accomplishing their goals and adjusted when appropriate.	①	② ③ ④
d. Patients and families are actively linked with community resources to assist with their self-management goals.	①	② ③ ④
e. Patients and families are provided with tools and resources to help them engage in the management of their health between office visits.	①	② ③ ④
f. Personalized shared care plans are developed collaboratively with patients and families.	①	② ③ ④

6. POPULATION MANAGEMENT	NOT AT ALL ▼	COMPLETELY ▼
a. Our practice uses a standardized method or algorithm for identifying its high risk patients.	① ① ② ③ ④	
b. Our practice has a mechanism for identifying and stratifying high cost patients.	① ① ② ③ ④	
c. Our practice has a system to assist patients with social determinants of health (such as transportation, financial situation, personal safety, etc.)	① ① ② ③ ④	
d. Patients with care or outcomes falling outside of guidelines are identified for more intensive care.	① ① ② ③ ④	
e. Our practice has a patient recall system to identify and bring in patients for needed care.	① ① ② ③ ④	
f. Our practice provides care management services for patients identified as being high risk or needing additional assistance and/or contact between visits.	① ① ② ③ ④	

7. CONTINUITY OF CARE	NOT AT ALL ▼	COMPLETELY ▼
a. Our practice has a system to insure that patients are able to see their own clinician as often as possible.	① ① ② ③ ④	
b. Our practice tracks the percentage of patient visits that are with the patient's personal clinician.	① ① ② ③ ④	

8. PROMPT ACCESS TO CARE	NOT AT ALL ▼	COMPLETELY ▼
a. Patients can reliably access care from our practice after hours or on weekends.	① ① ② ③ ④	
b. Patients and families can reliably and quickly access their personal clinician or a care team member to answer questions or deal with problems.	① ① ② ③ ④	
c. Patients can reliably make an appointment with their personal clinician or a care team member within defined and acceptable time periods.	① ① ② ③ ④	

9. CARE COORDINATION	NOT AT ALL ▼	COMPLETELY ▼
a. A structured system is in place for assuring appropriate follow-up and care planning for patients undergoing transitions of care (such as discharge from hospital, ER visit, etc.)	① ① ② ③ ④	
b. Our practice chooses where to refer our patients based on cost and quality of care.	① ① ② ③ ④	
c. Collaborative agreements have been developed with key specialists and community resources for communication, coordination of care, and handoffs.	① ① ② ③ ④	
d. Our practice communicates actively with specialists and community resources to coordinate care based on the patient's personalized care plan.	① ① ② ③ ④	



<b>10. BEHAVIORAL HEALTH INTEGRATION</b>		NOT AT ALL	COMPLETELY
<i>Note: "Behavioral health" includes mental health, health behavior change, and substance abuse services.</i>		▼	▼
<b>Organizational alignment</b>			
a. Our practice has a shared vision for behavioral health integration that everyone understands.		①	① ② ③ ④
b. Our practice has selected behavioral health conditions for quality improvement through routine collection and use of practice-based data.		①	① ② ③ ④
c. Our practice's business model and resource decisions support the consistent delivery of integrated behavioral and medical services.		①	① ② ③ ④
<b>Clinical collaboration</b>			
d. A behavioral health professional has been fully integrated into patient care in our practice.		①	① ② ③ ④
e. Personalized patient care plans are shared between behavioral health and primary care providers.		①	① ② ③ ④
f. Our practice coordinates care with behavioral health specialists and community resources that are needed outside the clinic.		①	① ② ③ ④
<b>Clinic systems</b>			
g. A system has been implemented to screen or otherwise identify patients with behavioral health conditions, concerns, or contributing factors.		①	① ② ③ ④
h. We have reliable registry data to identify and manage specific populations of patients with behavioral health concerns.		①	① ② ③ ④
i. Protocols and work flows have been implemented for collaboration between primary care and behavioral health providers, such as effective handoffs, communication, and standardized follow up.		①	① ② ③ ④

Practice name: \_\_\_\_\_

Date Monitor completed: \_\_\_\_\_

Original version developed by the Department of Family Medicine, University of Colorado School of Medicine (Aurora, CO) and Health TeamWorks (Lakewood, CO). Revised 8/15. ©2012 Perry Dickinson, University of Colorado School of Medicine—perry.dickinson@ucdenver.edu. Please contact for permission to use. The Behavioral Health Integration section was developed in conjunction with C. J. Peek to be consistent with definitions from the AHRQ lexicon for behavioral health integration: <http://integrationacademy.ahrq.gov/lexicon>.



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CHES is a collaborative, multi-stakeholder organization that seeks to improve health and health care across Colorado through: 1) supporting redesign and innovation in primary care practices, improving their readiness for new payment models through practice transformation support and infrastructure development; 2) promoting local collaboration among health care providers, community groups, patient advisory groups, local public health officers, and public health agencies; and 3) facilitating local or regional efforts to improve health care to meet the Triple Aim of improving quality, improving experience of health care, and reducing costs.