

**Medicaid Innovation Accelerator Program (IAP)
Physical and Mental Health Integration
Measures That Matter: State Measurement Strategies that Drive Integration
October 30, 2017**

Kitty Purington, senior program director at National Academy for State Health Policy (NASHP): I will be facilitating the discussion this afternoon.

Natalie Williams: [intro logistics]

Kitty Purington: Our agenda is:

- An overview of the IAP's physical and mental health integration (PMH) initiative.
- Highlights of some emerging themes and strategies from our work with states.
- Speakers who will talk about how to approach measurement in ways that can support integrated care and some innovative work being done in Colorado through a SIM (State Innovation Model) grant.
- Questions

Kitty Purington: Our presenters:

- Karen Llanos: Director of Medicaid IAP
- Dr. Harold Pincus: Professor and vice chair of the Department of Psychiatry at Columbia University and also the director of quality and outcomes research at NewYork-Presbyterian Hospital
- Leilani Russell: Data coordinator and analyst for Colorado's SIM office

Karen Llanos will present a brief overview of the PMH initiative.

Karen Llanos: I'm going to give a little context on how we developed this webinar services at IAP, the Center for Medicaid and CHIP Services (CMS) and Center for Medicare and Medicaid Innovation (CMMI) model, which works with state Medicaid agencies to support their state Medicaid delivery reform system efforts. As part of our physical and mental health integration activities we worked with nine states over 12 months to enhance or expand their different types of integration approaches. The different types of topics/issues that came up commonly were:

- Administrative alignment
- Payment and delivery system reform
- Quality measurement

We took all those and have tied them into a series of webinar topics. Today we'll be talking about quality measurement. This is the second in a series of four national webinars for our physical and mental health integration program area. The states we worked with, and who helped us highlight and identify key issues that could be translated into learning for a national audience, are listed on the slide in front of you.

Quality measurement continues to be one of the challenging measures.

Kitty Purington: Before the additional content, we have the first polling question. *What is your biggest challenge in designing and implementing strategies that measure integrated care?* Some things we've heard are:

- Identifying measures that support your specific state's goals
- Understanding what to measure regarding integration such as care coordination, practice transformation, accessing the necessary data to build those measures
- Incorporating integrated care measures into alternative payment methodologies (APM)
- Other

Polling is closed. Looks like a primary challenge is really understanding what to measure around integrated care and then identifying those measures is a close second, followed by accessing the data needed.

I'm going to talk briefly about measuring integration and some themes and strategies we have been talking about with states and states raising with us. As Karen mentioned, this IAP initiative worked with a number of states that are promoting and measuring the integration of physical and mental health in a number of different ways. So while the projects are diverse, a few common themes emerge from the work about how states approach this kind of service delivery transformation effort and also how they measure it.

Certainly as a preliminary step we found that states find it very helpful to spend some time defining their state's goal and vision around physical and mental health integration. Because this looks so different across states, it can be helpful for the states to really understand what they're trying to do and what they want their integrated care models to look like in their state. It can involve different providers, different target populations, and different ways to transform care. These definitional pieces can really impact how the state will want to track and measure their initiatives.

We also heard that engaging stakeholders in planning measurement strategies can be extremely helpful. States certainly are working with providers and consumers in this work. They are also developing cross agency internal teams to make sure they are engaging both Medicaid and behavioral health and other key internal partners. Several states were also supported by external committees and worked, sometimes with external resources that helped to convene, develop and report out recommendations.

State policymakers also found it helpful to leverage existing models and definitions such as the AHRQ framework for measuring integrated care and the integrated care lexicon from AHRQ. SAMHSA also has developed a standard framework for levels of integrated care that some states used and found helpful to frame their thinking around measurements. Other states have looked at evidence-based integrated care practices such as Screening, Brief Intervention, and Referral to Treatment, also known as SBIRT, or the collaboration care model, and used these more specific models as a way of identifying the components they could then use to track and measure progress.

Certainly all states emphasize the importance of aligning measurement strategies with existing measurement activities in their state. To do this, states have done things like inventory measures, currently in use to look for gaps in measure, that could help them better understand whether integrated care was happening and the impact it was having on population outcomes. As with other measurement selection processes, states found that prioritizing measures and reviewing the feasibility of collection reporting are always very important steps in thinking about how to compile those measures into a framework that's going to work.

Finally, many states are using a combination of structure, process, and outcome measures to understand how these integration efforts are changing and improving care. We will hear more about this as part of today’s presentation. There is an interest in understanding whether practice capacity and behavior is actually changing. For instance, through structure and process measures. And if so, what impact these changes are having on health outcomes through more population-based outcomes and measures.

Because there is a scarcity of measures that really target physical and mental health services, states may find it helpful to measure the transformation in a number of different ways. So compiling those structure, process and outcome measures in ways that can kind of tell states the whole story.

Dr. Harold Pincus will now discuss research he has been doing on this issue on ways that states can structure and improve their measurement strategies for physical and mental health.

Dr. Harold Pincus: The first slide focuses on the key issues I will be talking about.

- Just getting a general understanding of the interface between physical and behavioral health.
- Thinking about the concept of measurement-based care as kind of a core underlying framework for how one would conduct measurement activities in this space.
- What are the key organizational principles that underlie at a clinical level how one might provide a framework for advancing integrated care?
- The concept of creating a balanced portfolio across different types of measures of structure, process and outcomes.
- To think about how one incentivizes the implementation of effective evidence-based care by employing key strategies at policy levels.
- Looking at challenges to effective management both from a scientific and a practical perspective.
- Considering the notion of shared accountability across both the behavioral side of things and the general health side of things as a core concept in terms of ensuring accountability.
- How we've done a project to actually create a measurement agenda in this area.

First, a reality check. Because I think it’s important to hit home at some of the realities of what we ideally would like in terms of the kinds of measures we would like to have, to think for a moment about how do you choose a doctor for yourself, your children, parents or family, then think about how you might choose a mental health provider for people close to you. And how you determine, if someone is in behavioral or mental health care, whether or not they are actually getting high-quality care, whether primary care or mental health care. Then step back and say what data do you actually look at to make those determinations for your own personal decisions, and what data do you wish you had in order to make those decisions. That context brings home what might be important as you think about developing approaches to measurement.

Secondly, we actually begin to think about what are the kinds of situations in which we’re talking about measurement at this interface. Here are three examples:

- Consider a 35-year-old man with schizophrenia, diabetes, and tobacco dependence. Somebody like that can expect to have as much as a 25-year shortened lifespan with increased medical costs all along the way.

- Or a 25-year-old HIV-positive female intravenous drug abuser with posttraumatic stress disorder. A person like that is likely to encounter frequent emergency department visits, to not likely be terribly adherent to their medications, and also to be faced with increased medical costs.
- A 60-year-old woman with diabetes, congestive heart failure, and depression. Here the scenario is likely to involve frequent hospitalizations and early re-hospitalizations, problems with health management and adherence to her complex medication regimens, and becoming an early candidate for long-term care, again associated with high costs.

You need to think about this from the point of view of both sides of the interface, that what you see is patients that are primarily in contact with the general medical or primary care sector with comorbid behavioral health conditions in the mild to moderate range, such as people with depression, substance use disorders, anxiety disorders. In many cases, these people are not identified as having a problem or if they are identified they are often treated as having an acute problem with limited followup. That's one of the problems in general our healthcare system faces is there's not as much attention to the need to think of these conditions as longer-term chronic conditions with a longitudinal perspective.

At the same time, the other side of interface are patients with severe and persistent behavioral health conditions. For example, people with schizophrenia, bipolar disorder, drug addiction, who are treated primarily in behavioral health settings. These individuals often have poor self-care, poor hygiene habits. Their medications may worsen their general medical conditions, and the providers seeing them primarily on the behavioral health side may not have that much connection to primary care, primary disease care, and preventive care. Part of the problem we have is that medical and behavioral health providers are often operating in silos. We need to think about measures that encourage more connection and integration. One way of moving toward that is to think about measurement-based care as something that applies across both sides of the interface.

The notion here is that we think about people with behavioral health conditions as for the most part having longer-term chronic illnesses. They need strategies to treat those illnesses much like we do to treat diabetes, hypertension, arthritis, etc. One approach is to apply systematically clinically appropriate measures over a long term, whether it's hemoglobin A1c for diabetes or the PHQ-9 for depression or the Vanderbilt Assessment Scales for Kids, and essentially to have a measurement toolkit for conducting these screening and assessment tools over time to see number one to screen who needs care and number two to assess people over time to look at responses to treatment. This means we have to assure that there's a consistent longitudinal assessment over time. Whether that requires ruthless followup or managed care management, basically the idea is to not let people fall through the cracks.

The other aspect of this is that we're not just measuring for measurement's sake, but we're actually doing this in an action-oriented way so if people aren't getting better we actually choose for additional intensification of treatment based on looking at a menu of evidence-based options or step care for increasing the level of care so that we do get a response. To do this we need a practice-based infrastructure that enables providers to be able to follow people longitudinally to actually be able to view the changes in these measures and have some registry capacity that enables them to see when people need to be reassessed and to offer some assistance in terms of determining what are the options for step care. It also requires that we have adequate connectivity among the systems, so that there's an ability to have arrangements between and among primary care and behavioral health organizations and often with substance use and social service organizations so that there's an ability to have some referral networks and communication understandings so the information gets shared.

Then at a policy level we want to have incentives to establish structures like registries and other types of care management and the supports for this measurement-based care operation that are likely to be able to produce outcomes that can be reported to state or other agencies.

To build this measurement-based care infrastructure, there are 10 key organizational practices behind it. Number one is there need to be formalized partnerships between and among primary care and behavioral health organizations. Whether a memorandum of understanding, but that are clear with regard to the specifications about who's responsible for what, what are the arrangements for referrals, what are the expectations with regard to communication and coordination, what are the expectations in terms of the consultation and advice that can go back and forth and the kind of ways in which the providers across the two sides of the interface can engage with regard to care of an individual patient. In many cases people think of it as co-location, but I think it's important to understand that co-location—having the behavioral health provider located in the primary care setting or the reverse—is almost always very helpful but it is neither necessary nor sufficient to assure effective integration. There really still has to be this kind of understanding between the two organizations.

It is important to develop a way to predict who's going to need this kind of care so that one can identify people early and track people as part of a population management strategy, and ideally to have some ability to do some predictive modeling. You want to assure effective communication so again there are agreements and arrangements about how information would be shared ideally with some kind of shared medical record, and certainly at a minimum with some kind of shared longitudinal management plan.

Number four, as I said earlier, there needs to be some help to maintain the interstitial services to make sure people don't fall through the cracks, to have care managers available that can help engage patients to make sure that they're participating in this measurement-based care strategy. Having clinical registries, the information system to actually support that tracking system, is also essential. Ideally that registry is supported by additional decision support that is able to show people what the alternatives are if people aren't getting better and how to move up in terms of step-based care.

It's also important to not think of this just purely in terms of medication management. In many cases, it is helpful to have access to psychosocial services that are evidence-based, and that's also part of the arrangements between and among behavioral health and primary care providers. There also has to be an expectation that patients and also families are participating in the care, and that there are effective self-management strategies built into this process. There also very often is a need for a linkage with community services and social services, especially for people that are at high risk because of homelessness or poverty.

Finally, this model of care requires that you're continually evaluating how individual patients are doing, but also how the system is doing as a whole and conducting continuous quality improvements. A lot of these components really require some sort of health information technology to assist practices in implementing this approach.

This depicts an approach that Henry Chung from Mountain View Hospital and I developed to think about the different elements of effective integrated care and how a practice can build across from a preliminary to intermediate to advanced stage of integration. I'm not going through the whole continuum. That is available online and we can send you specifics about how to look up the monograph devoted to this. But this is a way of describing the initial structural components needed in terms of thinking about how to actually measure this at a practice level.

Part of what we're getting at is how do we create a balanced portfolio of quality measures that enable both improvement and accountability for practices. This applies both from the point of view of having

primary care practices that are able to implement effective integration strategies as well as behavioral health practices but mental health and substance abuse that are able to integrate effective integration strategies. For what we've been talking about so far it's been focusing on the structural measures, which are basically answering the question of are there adequate personnel training, facilities, quality improvement infrastructure, information technology resources, and other policies that are available for providing effective care? Are these things in place? Are there structures that support the use and reporting of outcomes? These are the kinds of structures often thought of in terms of what the joint commission expects with regard to hospitals, but also are encountered when one looks at a recognition program such as patient-centered medical homes. There is now a state demo program that CMS and SAMHSA are administering around certified community behavioral health clinics, which is in the Protecting Access to Medicare Act, sec. 22-23. Then also this continuum model I just alluded to is another example of how one can begin to develop some ways of looking at measuring whether or not these structures do in fact exist.

The intention is that these structures should show the capacity to do things. But the question is are evidence-based practices actually being provided? That's what process measures are primarily looking at, both on the behavioral health and general medical care side. Are we doing proper screening? Is there adequate followup? Are people with severe mental illnesses getting access to the necessary preventive care recommendations? Are people in primary care settings getting screened for depression, getting followup, and getting appropriate care? Are people underusing certain services or overusing certain services? Are the services being provided in the appropriate way to the right people? Are they being provided with fidelity to what the evidence base that supports them shows?

For example, are people initially screened for depression, identified as having and treated for depression, are they getting serial follow-ups to see whether they're improving or not? If so, are adjustments being made in the treatment strategies to try to intensify care? It's the same kind of thing you would think about in terms of looking at people with diabetes in terms of thinking about whether their hemoglobin A1c is within range or whether different efforts are made to try to bring it within range. Similarly, with people with hypertension, to measure their blood pressure serially over time and looking at whether care is being used to make sure the blood pressure is within normal bounds.

The next step is to also have a balance with outcome measures. The question there is are people actually getting better? Is the care improving outcomes? Here is where you want to ensure there are some ways by which those are measured and have the capacity to be reported. So obviously with things like hypertension, people can report the blood pressure at given points in time and then you could see whether or not people have achieved success in receiving a normotensive level. There again, for depression, you can do something similar, using the PHQ-9, having a registry in which we're looking at whether PHQ-9 has been assessed over 3-, 6- and 12-month periods, and whether or not people are achieving remission or clinically significant improvement that is typically thought of as 50 percent improvement. Again to think about this from both sides of the interface in terms of looking at the people of people with mild to moderate depression or anxiety and seeing whether they're improving, and looking at people with severe illnesses like schizophrenia who may also have a comorbidity of diabetes or cardiovascular disease, and are they improving with regard to their general medical condition.

It's also important to think about the other domain of patient experience. What is the patient experience like? This is primarily through survey data. One could think about the patient assessment of the degree to which they had access to either behavioral health or general medical services; the effectiveness of communication with their providers; the extent to which they feel engaged in making decisions. Finally, part of a balanced portfolio is to also think about cost, efficiency and overall resource use to assess the overall expense in providing care, whether the resources are being used in an efficient way, and looking

at things such as readmission on the behavioral health or general medical side, on total cost of care, or on whether there's overuse of certain low-value procedures.

So at a policy level you want to think about how you can utilize these measurement approaches to incentivize providers and systems of care and clinics with both financial and nonfinancial incentives. To think of ways by which to measure that at a patient level, provider level or practice level and plan level, and ultimately at a larger state and policy level, how one can use different types of policy levers to influence that. The part I mentioned earlier is that through some of the recognition programs to make sure that there are discussions in place that actually enable practices to both utilize and produce and report outcomes to develop a set of national quality integrated care measures. I'll talk in a moment about something we did to help develop an agenda in that area. To alter the contractual and/or organizational arrangements between and among providers and also between and among payers, especially with managed Medicaid to build in mutuality of incentives across managed care organizations and carve out managed behavioral health care organizations to help with developing the necessary information technology infrastructure and ways of helping support communication between and among primary care and behavioral health organizations, and help to build some of these non-health social services. And importantly to begin to establish a culture as well as strategy for shared accountability.

When I talked about shared accountability, the idea is to break down silos. It's a relatively simple concept but it's really hard to implement. Particularly it's hard to build into a culture. So basically the idea is applying these same measures and expectations to all the entities involved in the care of the patient. Take, for example, I'm a psychiatrist treating a patient with schizophrenia and diabetes. I'm accountable for the outcomes in both the schizophrenia domain as well as in the diabetes domain for my patient. At the same time, my colleague, the patient's PCP or gynecologist or endocrinologist is equally responsible for both the outcomes for the diabetes as well as the schizophrenia, which means that we have to talk to each other and we have to coordinate. And we have to share information so we can more effectively treat this patient. That applies again not just for the providers but also for the health plans as well, that they have to have a mutuality and shared accountability, and that we have to move towards substantiating this kind of approach as we train providers, as we conduct our practices, incorporate that into managed care contracts and performance incentives. Again to move towards creating a culture of shared accountability.

There's a number of key challenges to effective measurements:

1. We don't have total knowledge. There needs to be continuous improvement of the evidence base and also having an evidence base that gets very specific about what works and what doesn't work.
2. We have to have some agreement about how we incorporate some of the measures that we're using with this hemoglobin A1c, which is already captured in most electronic health records, but some of the behavioral health concepts are not well-integrated into health information technologies in an intra-operable way so that we can routinize the approaches to measurement-based care. This also applies to some of the issues around how we capture some of the information about psychosocial interventions so that we can actually look at whether or not psychosocial interventions are properly being applied in terms of the appropriateness of the fidelity to which they're being provided to patients and that they're matching what the patient needs. Because right now pretty much the only information we have is that it was a 45-minute psychotherapy.
3. We need to build better capacity to capture data so that we actually know what's going on, not just simply use checklists.

4. Begin to do more work around figuring out what are the appropriate benchmarks, what is an appropriate expectation for performance on these measures?
5. To develop better ways of doing risk adjustments so that clinical entities are not penalized for providing care to people that are more severe.
6. We need to look at the risks of moving ahead too quickly. A good example of that is that diabetes has been like the poster child for quality measurement in which the evolution of quality measures in diabetes went from what proportions of patients with diabetes in your practice had a foot or eye exam in the past year to what proportion of them had a hemoglobin A1c in the past year to what the level of the hemoglobin A1c was in the past year to what proportion was below 9, below 8, and below 7. Then the ACCORD Study comes out and finds that people with hemoglobin A1c below 7 had higher mortality rates. We may have moved too fast in that regard and not have considered the fact that different individual patients may need different strategies, that a 70-year-old woman with diabetes may not need as tight glucose control because the risk of them getting hypoglycemic, falling and breaking their hip and so on, as compared to a 40-year-old otherwise healthy type 1 diabetic in whom a hemoglobin A1c below 7 would be perfectly appropriate. So we have to customize some of this.
7. Also understanding who is responsible for forwarding and funding measure development, and realizing that in many ways, behavioral health providers are far behind in terms of the implementation of behavioral health information technology given that the HITECH Act actually excluded non-physicians and organizations that were not hospitals.
8. In the behavioral health sphere there's a great deal of heterogeneity in the kinds of providers working in this space. So we need the higher expectation about more universality of training with regard to some of these evidence-based practices and the application of quality measures and quality improvements.

In terms of developing a measurement agenda, we were fortunate to be funded by the Commonwealth Fund. To develop a measurement agenda at this interface, again looking at both sides of the interface, in which we did a literature review of both white and gray literature of different types of potential measures across those five domains of process, structure, access, outcomes and patient perceptions, and cost and efficiency. We went to a Delphi panel process to identify and prioritize those measures and several key issues came up.

One is that we should think of serious mental illness as kind of a disparities category. Two is that there actually are a set of measures that if we can engage by determining the quality measurement industrial complex or the groups of entities at a national level that steward and fund the development of measures to again give an outline or menu of things that can be done at a high priority.

We published several papers on this. This shows one important paper published in the *International Journal for Quality in Healthcare* that lays out a conceptual framework for the further development of these measures. That agenda focused in a number of different areas. One was thinking about in particular how we stratify existing measures to look at people with severe mental illness as a population in particular in need of better care. Then looking at it from the general medical side, that is, general medical care for individuals with behavioral health conditions, to think about developing measures in domains such as providing general medical screening and diagnostic assessment and prevention. For example, whether people with behavioral health conditions are getting adequate screening for tobacco cessation? For cancer? Are they getting adequate care for the chronic general medical conditions they're getting? Is there adequate continuity in coordination of care? Do they have access to general medical care?

On the other side of looking at always providing adequate behavioral healthcare in general medical and primary care settings, again to look at the same set of issues but from the point of view of is there adequate screening for mental health and substance abuse conditions? Are they being provided with behavioral health evidence-based treatment? Are they being provided with patient-centered care from the patient's perceptions of care? To what extent are referrals being adequately implemented? Are we providing continuity in coordination of care? Are we providing access to that care?

Then there are things that cut across both of those in terms of access to social services, cost and efficiency, and continuity and coordination.

One of the key issues is probably low-hanging fruit for measuring quality care, especially for individuals with serious mental illnesses such as schizophrenia, bipolar disorder, drug and alcohol dependence, and in segmenting existing measures for which there is relatively available data and looking at the performance for that segmented population compared to the broader population that's in the denominator of that measure. That's important because this group of individuals actually is justified as a disparities category because one, they have a high level of general medical comorbidity. As I suggested earlier, they die 10-20 years earlier; they have a great lack of access to primary and preventive care; and they are much more likely to get poor quality care.

As I said before, this is an easily implemented measurement strategy, so you can take, for example, existing endorsed measures for this population, already collected measures. Whether it's the receipt of preventive health interventions, of screening for different types of preventive health interventions that have been recommended by the U.S. Public Health Service Task Force on Preventive Care, whether they received expected immunizations. Or we can look at process and outcome measures for common general medical comorbidities such as smoking, diabetes, hypertension, cardiovascular disease that again were the measures already collected and reported, and to look at this segment of individuals with serious mental illness in comparison to the full denominator of individuals pulled into those measures. Then in addition to having it as a measurement strategy on a measure by measure basis, to also include this information in national disparities reports.

In fact, many of these so-called segmented measures have already been endorsed by the National Quality Forum. These are listed in that next slide that I'm not going to go through. They are all basically feasible to measure at a state level if they're being reported generally. One could look at the performance specifically with regard to this part of the general medical and behavioral health interface. I'll stop and take some questions.

Kitty Purington: Thank you for that thorough presentation on how we can think about measurement, about shared accountability for integration and related issues. Could you briefly speak to an issue raised in the chat box, which is to talk about where the field is going in terms of measuring things that may matter to families and consumers that may not necessarily be easily captured, things like quality of life and functioning? You talked briefly about measurement-driven care. Just wonder if you have any thoughts about that.

Dr. Harold Pincus: In fact, there are a number of strategies for doing that. There are in fact measures that can be applied in what people term the recovery domain, both at a practice level or clinic level in terms of whether the clinic has implemented strategies that are more recovery-oriented strategies such as different strategies for patient engagement, the use of peer counselors and so on. Then number two, at an individual level, in terms of different types of survey instruments that include items related to recovery and patient engagement. So these measures exist.

Part of what I'm suggesting is there is a need to develop a kind of measurement toolbox where at a practice level you can incorporate into your standard operating procedures on a longitudinal basis certain measures that capture both clinical-related levels of response and also recovery in patient perceptions in terms of their perceptions about their experience of care.

Kitty Purington: That holds a lot of promise, especially as practices have become more adept at using clinical data and those kinds of tools. Now, Leilani Russell will talk about Colorado's extensive experience in measuring physical and mental health integration as part of a SIM initiative.

Leilani Russell: I am our data coordinator and analyst for Colorado out of our State Innovation Model office. With Colorado SIM, we have an overall goal to improve the health of Coloradans by improving access to integrated physical and behavioral healthcare services in coordinated systems with value-based payment structures for 80 percent of Colorado residents by 2019. This is what we term our 80 percent goal. The way we're going to get there is by looking at our Four Pillars of payment reform, practice transformation, population health, and HIT. The SIM office went to great length to ensure that the pillars are a part of our work group, and those work groups are represented by communities and stakeholders across the state of Colorado. That was a very big and lofty goal.

Now we're going to talk about how we think we can get there and more importantly how we think measuring that will show success. What we have again is our overarching SIM goal. There are three components to reaching SIM goals:

1. Access to integrated healthcare.
2. Healthcare supported by APM.
3. Healthcare in communities with coordinated systems.

And since the parts fuel progress toward the healthcare system that improves measures in each of these spheres. Each sphere will be assessed during and at the end of the SIM initiative in July 2019. Progress and achievement will be determined by comparing the subsequent status of these measures at different measurement points along the time of the initiative, and kind of how things change from baseline. That will really help us contribute to measuring the success of our 80 percent goal.

When I talk about measuring impact, we have a lot and lot of measures and I don't plan to go through all of these. But at a high level we have:

- Clinical quality measures that are reported on directly from our primary and community mental health centers.
- Population health measures that look across the state.
- Cost and utilization measures.
- Model participation or what you would consider process measures.
- Access to care.
- Additional evaluation measures.

The way we've gone about prioritizing the measures we're looking at has been a process that can be broken down into two areas. We have what is required for reporting to the Center for Medicare and Medicaid Innovation. With model participation there are again those process measures. We also have

some outcomes measures, and then payer participation to understand APMs and hopefully the impact they have on practices.

Again we have our work groups, and we have seven of them:

- Practice transformation.
- Health information technology (HIT).
- Population health.
- Evaluation.
- Consumer engagement.
- Policy and workforce development.

These work groups are really manned by volunteers, by community and subject-matter experts across Colorado, and they really help inform our overall process, the measures that we selected, and how we are progressing as an initiative.

Another thing we've done with prioritizing measures is we've tried to really align with existing initiatives where possible. We have a few here. Colorado's Medicaid program is also working on a primary care APM and this is something we've also been a part of in trying to align measures. We also have in Colorado a multi-tier collaborative, and we're working with them to really prioritize which metrics would be important for VBP models. The Multi-Payer Collaborative also supplies us with data that we've used to understand the impacts of payment reforms with integration of behavioral health and physical healthcare in Colorado. Those data collection efforts are aligned with the Healthcare Payment and Learning Action Network data collection effort nationally.

Across the board, what we've tried to do with any sort of partner, whether it's our practices or the payers at the Multi-Payer Collaborative, is really leverage existing data and infrastructure where possible. Again this is really to reduce the reporting burdens for practices and other partners.

We've talked a lot about data and I'm going to dig more into what we actually have in terms of where we're collecting from and what that data looks like. This is an example of the assessments that are collected in the Shared Practice Learning and Improvement Tool (SPLIT) that our SIM practices permit. There are a wide range of metric measurements to look at how practices are doing. I'm not going to go into all of these, but again we collect a lot of information.

An example of one assessment that practices do for SIM is what is called the IPAT, or the Integrated Practice Assessment Tool. It's a brief assessment that practices have done so far twice. Normally a lot of times when practices first do an IPAT they tend to rate themselves a little bit higher on the integration continuum than maybe they actually are. When we start really doing practice transformation efforts, they realize oh, this is a lot harder than I initially thought and when we reevaluate using the IPAT, we'll mark ourselves a little bit lower. Surprisingly, this did not happen with our SIM cohort 1 practices, probably reflective of the fact that many of them have been doing practice transformation efforts across the state for a while now. As we're bringing on our second and third cohorts, this is likely to change a little.

I'm going to briefly talk about some of the clinical quality measures that practices supply themselves. We have for adults and pediatric practices what are considered our primary CQMs, which is what we're saying we really want them to focus on trying to report to us, but also think about how these measures can inform their quality assurance processes. We have a range of them here. We also have some secondary

clinical quality measures. The reason we have these is that we know there are many times due to reasons outside a practice's control, like EHR issues or other things, they can't report on one of those primary clinical quality measures. So instead we're asking them to consider some of these secondary measures. Across the board all of these measures our SIM stakeholders helped determine the importance of these, which ones we should go with. Our stakeholders have a lot of valuable information and we rely on them heavily to inform our processes.

I'd also like to highlight the columns that show where these measures are aligned with the Comprehensive Primary Care Plus Initiative, MACRA's Quality Payment Program, Transforming Clinical Practice Initiative in Colorado, and again Colorado's Health Care Policy and Financing, our Medicaid department's APM that's going to be rolled out soon. So these are adult measures.

We also have pediatric practices that participate in Colorado SIM. A lot of times, at least in Colorado, pediatric practices aren't necessarily allowed to participate in initiatives like SIM, so we're really lucky to have some very, very great pediatric practices. They have a subset of measures, and again they have one secondary measure. For more information, click on the links (in slides).

At a process level, when we look at how practices have been doing, this shows the most recent data that we have from Q2 of this year. Overall our practices are doing really well. With Q2 of this year we actually had every single practice reporting on at least one measure. We're in the process of collecting data for Q3 so we'll have some more information to them soon.

Just looking at one of the clinical quality measures, the depression screening and followup, we see that initially practices reported it at about 45-46 percent, and there was a little bit of a dip down, and we're now back up to almost 49 percent. We think this is pretty good for our first cohort. Again this is just primary care practices. We do have four community mental health centers that are integrating primary care into their community mental health care setting. They also report on these exact same measures. We just don't have information to share with you guys yet.

We're looking at trying to measure access to care. What we've used is Colorado's All Payer Claims Database, and we're using data from that database to calculate for the Agency for Healthcare Research and Quality Access to Care Metrics; they're kind of a proxy for access to care for us. I also mentioned how we have the SPLIT and the various assessment practices do use that tool.

We also have ways of looking at the number of patients served by provider scoring of a specific integration threshold on the IPAT, the Milestone Inventory, and access estimate using the Colorado Claims Database data. This work is done by our state evaluator, who is a third party with the Tri-West Group. We also have the Colorado Health Access Survey, which is hopefully going to allow us to look a little bit closer into integrated healthcare in Colorado.

One of the things that could be helpful for those attending today is to really talk about some of the challenges that we face. I don't think it's surprising to anyone that there have been challenges, starting with the first area, that there is no one data source or measure for estimating access to integrated care. So even though we have these fantastic subject-matter experts on all of our work groups and fantastic team members, it really becomes a puzzle trying to piece together various data points. A few of the types of data we are using are listed here:

- Access to care (not necessarily integrated care)
- Behavioral health outcomes
- Primary care outcomes

- Clinical data
- Claims data
- Statewide data
- SIM cohort practice specific data
- Assessment data on milestones (interim process achievements)

Something else that we're calculating is a return on investment. So in Colorado we're expecting to save or avoid \$126.6 million in healthcare costs, and have an ROI of about 1.5 million by the end of the program, July 2019. These cost avoidances and ROIs are calculated by our partner, Milliman, and usually their organization is comparing the projected cost to the actual cost you see in claims data. What we're seeing preliminarily is that practices are creating cost savings in just the first year of implementation of SIM. Some very important caveats are they didn't incorporate risk adjustment yet. We're going to get there. It didn't include Medicaid data for the whole 2016 calendar year. It was only so far for the first half of 2016. Then once those caveats are addressed, Milliman will recalculate the ROI and projected cost savings and we'll release a Year One implementation report.

Something else I'd like to highlight in terms of ROI, I'm really talking about ROI from a payer perspective—payer whether it's an initiative or at the state level. But there's also an investment that practices make. One of the many tools that are helping practices understand their cost utilization data is to provide reports to them, hopefully quarterly, that they can use with their practice facilitation support that we paid for. So they really start understanding where practice transformation, integrated of physical and primary healthcare, makes financial sense for them, so that they can continue on this journey.

Questions?

Kitty Purington: I want to kick it off with questions around Colorado's infrastructure. I'm just wondering for other states listening to all the great work you've done there, what kind of internal infrastructure did you need to develop to prepare for all of this information that you want to be able to take in and use effectively? Can you talk about that process and challenges in developing that infrastructure internally?

Leilani Russell: I actually joined SIM after a lot of that initial work and thought process was addressed but I do have some background I can provide. One example is the SPLIT. This is a tool developed by our partners at the University of Colorado Department of Family Medicine. This is a tool where not only can practices take their assessment and see how they've done in the past, it's also where they report their clinical quality measures to us. By having an assessment like that already in place and then having a partnership with the university, which is a huge, huge benefit to us, we've really been able to leverage what's already in place. Because when I talk to other states trying to collect some of this information, it can be really, really hard. So having a one-stop shop for practices to supply their data to us has been one very helpful infrastructure that was already in place.

Kitty Purington: So you have it sounds like a web portal tool for providers to use. How have providers responded to reporting but also to measuring things that have previously been out of their purview and how have those conversations gone? What have been some of the successes and pitfalls in those discussions?

Leilani Russell: We knew, again, kind of our cohort was, those kind of trailblazers in Colorado in practice transformation efforts to integrate primary and behavioral healthcare so in some ways a lot of them have been similar initiatives or had done some of the assessments. So we had complaints here and there about

some technical issues like the portal is down or I forgot my login information, and I think those are just normal going to happen things.

One thing that did happen was initially our steering committee had a different subset of clinical quality measures selected. One of them was influenza immunization and another one was to have an anxiety clinical quality measure developed. Our steering committee was like, this is important, we really want to measure this. Then we started to implement it and to talk to providers and to the practice transformation organizations that helped them in their practice transformation journey. We really heard from them: “We can't measure some of these. To build a whole new measure into our EHR system is going to take a lot of money and a lot of time that we don't have, and the SIM office isn't really supporting us enough to do that.” So we took all that feedback and looked and went back to our stakeholders and provided that feedback, and we really simplified those clinical quality measures into the measures I showed you today. That was really a direct response to the providers and the organizations that support them through SIM.

Kitty Purington: This may be a question for both of you. Talking to states just starting out and thinking about not having an expansive capacity to do a lot of measuring. Is there some low-hanging fruit? Are there a handful of measures that may be a good starter kit for states who are just starting to put a toe in the water?

Dr. Harold Pincus: Obviously there's a set of NQF-endorsed measures that are out there, and there's some that are also measures that are part of the state's voluntary reporting program for Medicaid that are already on the list that there's been some communication with states to begin to implement those. I'd start there rather than trying to invent new measures, because there are measures out there that are reasonable. Many of them are not ideal and there still needs to be more measure developmental work. But to start with those two lists. Because also you want to be aligned. What Colorado has done is to try to make sure that the measures that they're choosing are aligned with different programs so that people aren't going crazy trying to have some similar measure but that's slightly different from another measure that's in a different program, so to try to aim for measure alignment. Try to look at measures that are already in place in different programs. Also to think about utilizing some of the NCQA recognition programs like the patients have a medical home. But also there's now an NCQA recognition program that's based around the patients have a medical home program but that also adds added—I forget what the actual term is but it's sort of with distinction in behavioral health. That's something to also look at and then think about how one might be able to provide added resources for those clinics that meet that criteria.

Kitty Purington: Leilani, thoughts about what a starter kit might look like?

LR: Yeah. Not necessarily a kit, but I can't really reinforce enough relying on the subject-matter experts you have as stakeholders. The Colorado SIM office is quite a small team, so to expect all of us to really understand clinical quality measures or how those are in relation to measuring things like integration of behavioral and primary healthcare would be really, really difficult to find. But we again have so many fantastic stakeholders in Colorado that have a lot of this experience and a lot of it's knowledge. So on top of the things that Dr. Pincus talked about would be to highlight relying on the subject-matter experts that are in each state and trying to engage them to become valued stakeholders.

Kitty Purington: Any other thoughts from either of you or others on the call or questions in the chat box? [none] Thank you for the different perspectives both of you bring to this topic. In terms of key takeaways, I want to briefly highlight what both our presenters emphasized today.

- Measuring integrated care really needs to include a diversity of measurement. Both our presents spoke to coming at this from different angles and using structure, process, outcome measures, and tracking cost, including access, as ways to understand the process of delivery system transformation toward a more integrated system.
- States can also use the emerging frameworks for structuring and measuring integrated care. Many states have found this helpful to understand where they're going, what the structure is they want to get to as an end state, before they think about how they're going to measure that process and those outcomes.
- As Colorado spoke to, infrastructure is certainly important, having the ability to interact with providers and gather data from a number of different resources: clinical data, claims data, practice assessment, and reporting. All of these can play a role in understanding what's going on in terms of system delivery transformation.
- I also heard alignment as a key theme, leveraging the measure sets and standardized measures that are available and often used already in state Medicaid programs.
- Talking to stakeholders, using homegrown expertise, state expertise across work groups, and engaging others beyond state Medicaid and behavioral health agencies to shape this work can be very valuable as well.

Upcoming National Dissemination Webinars for Winter 2018: One is building provider capacity, which will talk about how states are leveraging different state policies to build primary care capacity that can approach care in an integrated way. Also one on administrative alignment to understand better how states can remove specific barriers, whether in licensing and billing, things like that, that a lot of states have raised that are those issues that you get to when you are ready to implement your integrated care program but still have a few things that need to be addressed to really be successful.

[end of tape]