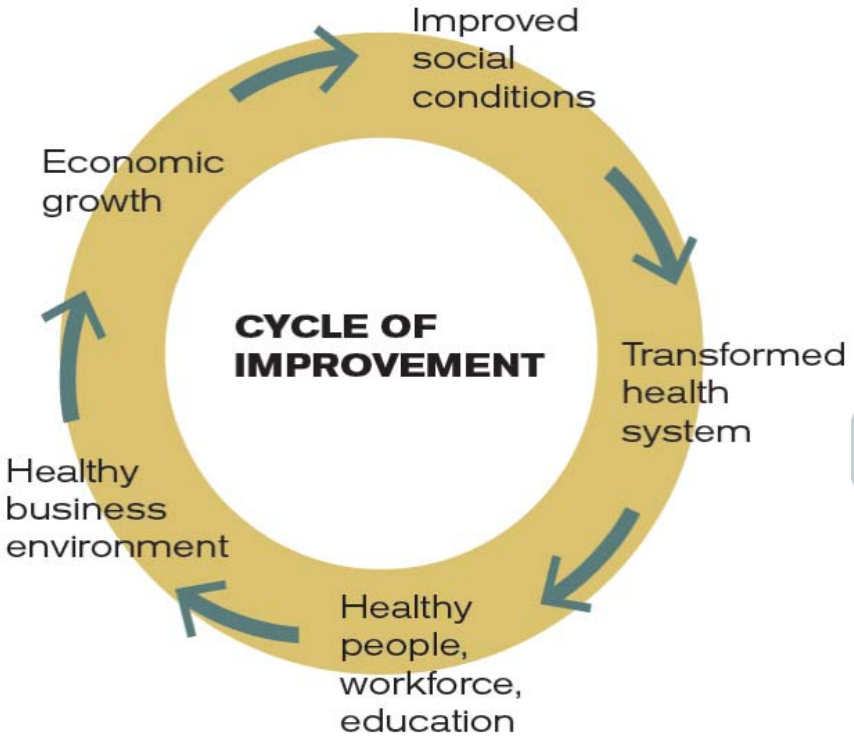
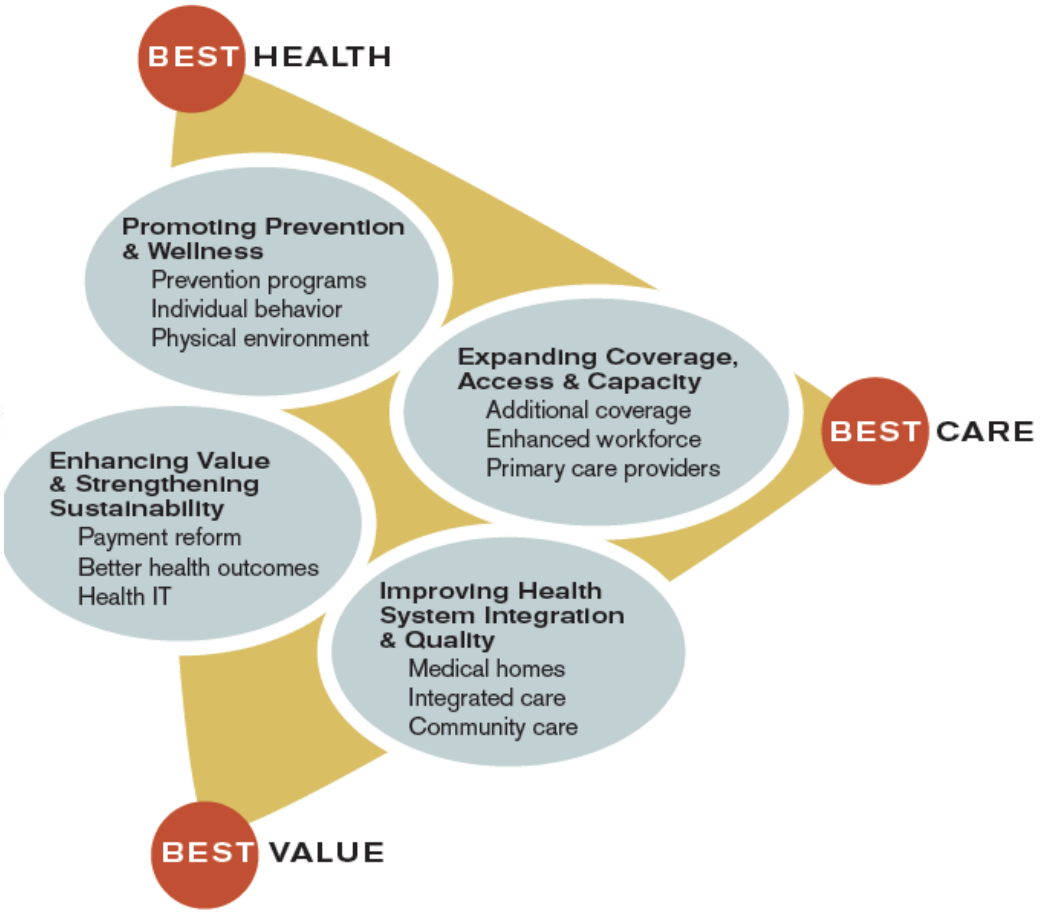
Colorado's Efforts on Better Outcomes in Health





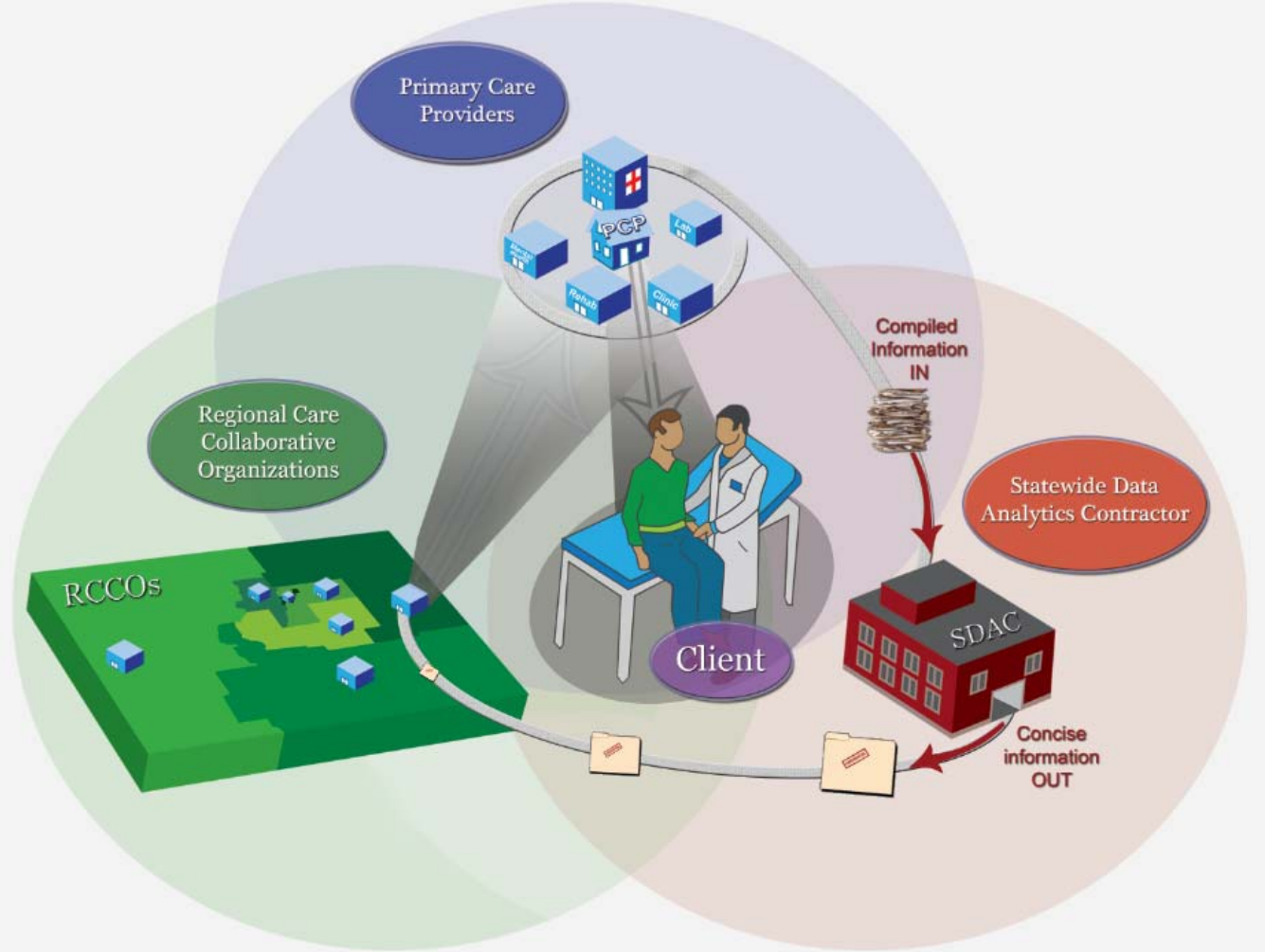
The State of Health





Historical Model

New Model


Primary Care Providers
PCP
Lab
Rehab
Clinic
Compiled Information IN
Regional Care Collaborative Organizations
Statewide Data Analytics Contractor
RCCOs
SDAC
Client
Concise information OUT

Successes of the ACC and care coordination

A diabetic male was unable to transfer his Food Stamps from one county to another. As a result the client began dumpster diving in order to eat. Not only did this new diet exacerbate his diabetes he also contracted bed bugs from the dumpsters themselves. As a sufferer of sleep apnea he was forced to sleep in a recliner, however due to the bed bugs the recliner had to be thrown away and the patient had to sleep on the floor.

With both of his conditions acting up, he often frequented the ER. After uncovering the needs of the client, the care coordinator was able to transfer his Food Stamps from one county to another and through the help of local charities they were able to get him a new recliner. He has not gone to the ER since.

SIM Opportunity for states

- Deliverable: State Health Care Innovation Plan (due Nov. 30)
- Multi-stakeholder input to develop vision and plan for public/private transformation
- Potential to apply for implementation funding early 2014
  - New York, Washington, California, Connecticut, Delaware, Hawaii, Idaho, Illinois, Iowa, Maryland, Michigan, New Hampshire, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Utah
  - Arkansas, Maine, Massachusetts, Minnesota, Oregon, Vermont

Vision

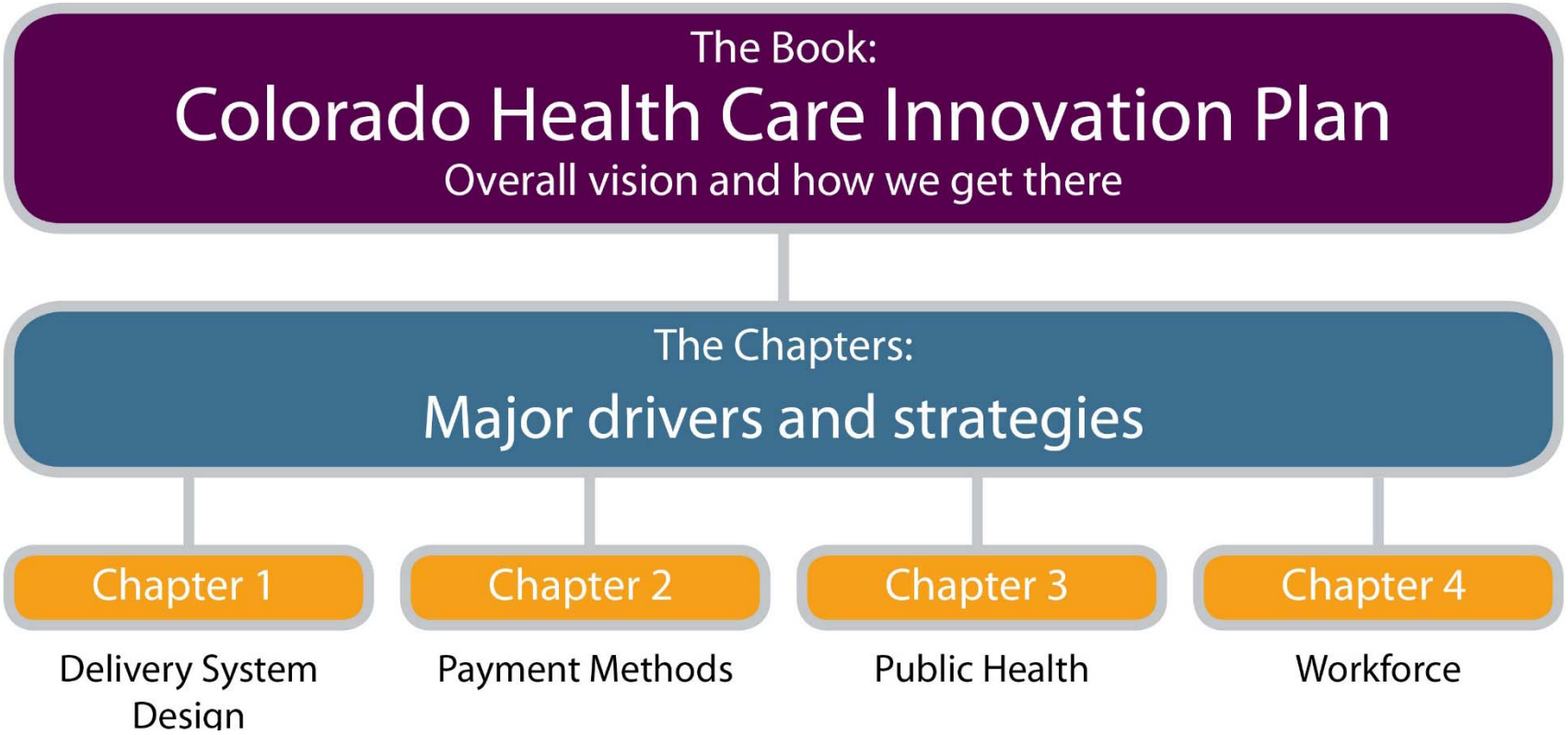
Colorado aims to become the healthiest state in the nation by:

- **Achieving** the complete integration of affordable, high quality health care for our citizens regardless of insurance payer
- **Ensuring that** each Coloradan has access to a trusted home for care that meets them where they are
- **Integrating** physical and behavioral health
- **Leveraging** the power of our public health system to support the delivery of clinical care and achieve broad population health goals
- **Creating** an outcomes-based payment system that enables transformation

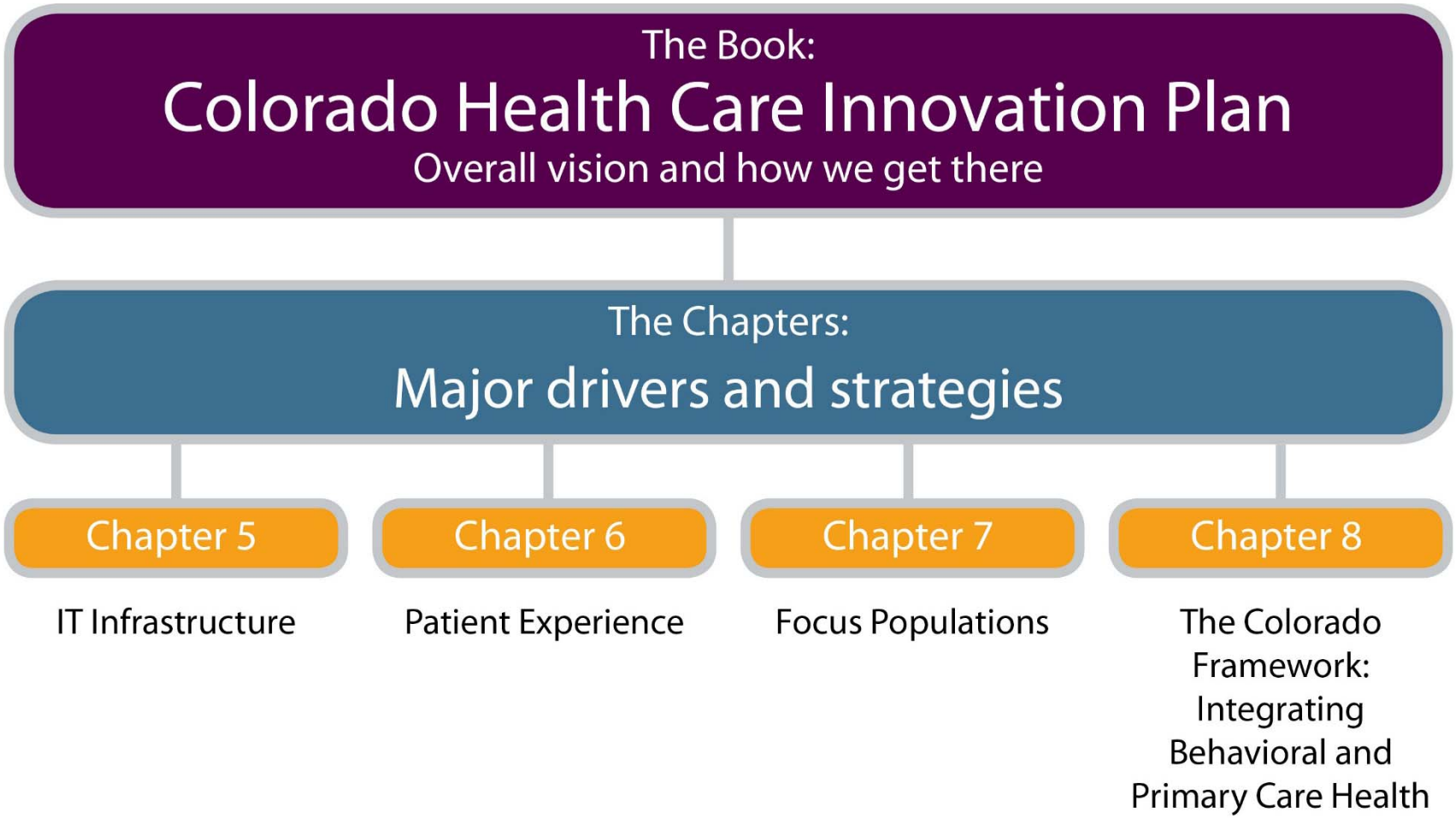
Stakeholder Input

- Advisory Group
  - 3 meetings by end of November; approve plan
- Steering Committee
  - Guide work, act as sounding board
- Provider, Public Health, Patient Experience Stakeholder Groups
  - Develop recommendations
- Contractors
  - Develop plans for payment models, practice transformation, HIE, etc.
- Other Informants
  - Payers

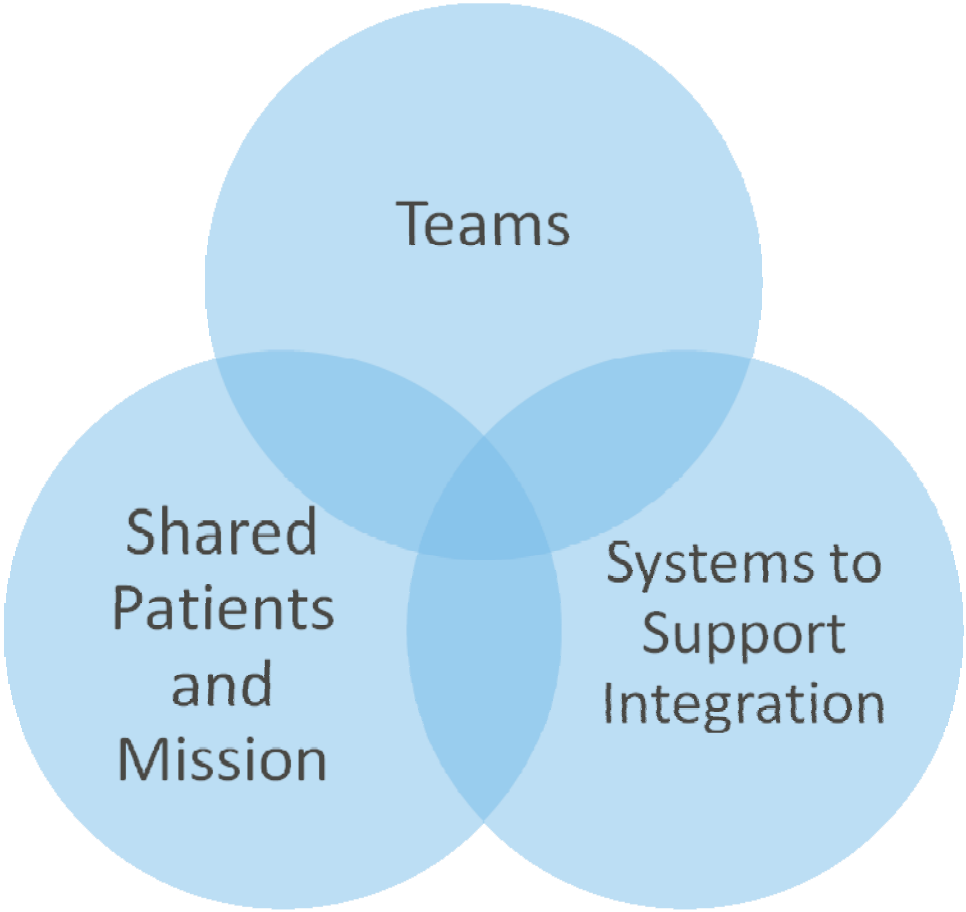
Innovation Plan: Book and Chapters 1-4



Innovation Plan: Book and Chapters 5-8



Defining Components of Integration



Defining Components: Team

Behavioral Health Providers and Range of Expertise	• Identify behavioral health needs of patient population • Provide appropriate interventions • Coordinate care with offsite services and link to community resources • Provide follow-up care and monitor outcomes • Social support and family interventions • Crisis intervention
Shared Operations, Workflows, Culture	• Regular communication, coordination, collaboration between team, patient and family • Reliable execution of systematic clinical approaches
Education and Training	• Key staff prepared to carry out functions of integration

Defining Components: Shared Patients, Mission

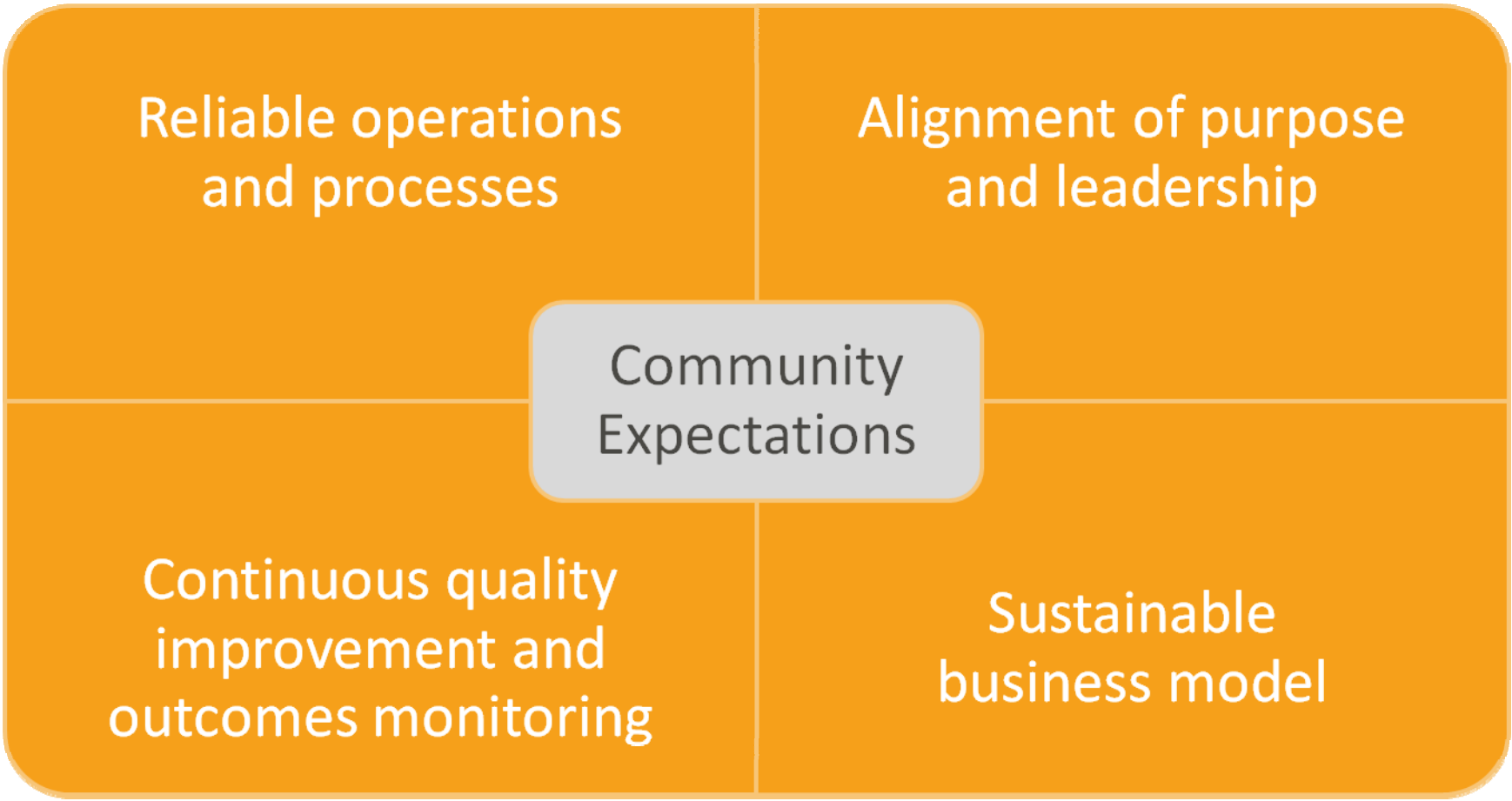
Shared Panel of Patients

- Team responsible for total health outcomes, both behavioral and physical
- Patients experience practice as home for all primary care
- Practice feels responsibility for all primary care

Defining Components: Systems

- Patient Identification
- Patient and Family Engagement
- Unified and Shared Care Plan
- Shared Electronic Records
- Systematic Follow-Up, Adjustment of Care

Supporting Components of Integration



Questions?

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