Colorado State Innovation Model (SIM) Cohort 2 - Practice Request for Application (RFA) Packet
REQUEST FOR APPLICATION (RFA) PACKET

For questions related to the Cohort 2 SIM Practice Request for Application (RFA), please email PracticeTransformation@ucdenver.edu or call 303-724-8968.

<table>
<thead>
<tr>
<th>SCHEDULE OF ACTIVITIES</th>
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<tr>
<td></td>
<td>(All times are local Colorado time)</td>
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<tr>
<td>SIM Cohort 2 Application Posted at:</td>
<td>February 15, 2017</td>
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<tr>
<td>SIM Cohort 2 FAQs Posted at:</td>
<td>February 15, 2017</td>
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<tr>
<td>SIM Cohort 2 RFA Submission Deadline</td>
<td>March 31, 2017 11:59 pm MST</td>
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<td>Applications Must Be Submitted Online By Date and Time Listed</td>
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<td>SIM Cohort 2 RFA Informational Webinar(s)</td>
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<td>To register visit the Colorado SIM Office webpage at:</td>
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<td><a href="https://www.colorado.gov/healthinnovation/register-c2webinar">https://www.colorado.gov/healthinnovation/register-c2webinar</a></td>
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<td>Or by clicking the individual hyperlinks below:</td>
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<td>• February 22 - Register Now</td>
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<td>• March 2 - Register Now</td>
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<tr>
<td>SIM Cohort 2 Anticipated Notification</td>
<td>June/July 2017</td>
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<tr>
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<td>August 2017</td>
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<td>SIM Cohort 2 Anticipated Start/Kick-Off</td>
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EXECUTIVE SUMMARY

The **Colorado State Innovation Model (SIM)** is an initiative funded by the Center for Medicare & Medicaid Services (CMS). The goal is to improve the health of Coloradans by increasing access to integrated physical and behavioral healthcare services in coordinated systems and encouraging SIM practices to test value-based payment structures. The SIM Initiative will reach 400 primary care providers and four community mental health centers during its four-year timeline and strives to influence the healthcare of 80% of Colorado residents through its efforts, which include regional health connectors and local public health agencies, by 2019.

To achieve this goal, SIM will select primary care practice sites from across the state to receive practice transformation support to help them integrate behavioral health and primary care and facilitate a transition to value-based payments.

The University of Colorado is issuing this request for application (RFA) on behalf of the SIM Office. Approximately 150 practice sites will be selected to participate in the second cohort of SIM and engage in practice transformation activities through the SIM Practice Transformation Program. These practices will join 92 practice sites that currently participate in the first SIM cohort. Participating practice sites will receive support from and work with practice transformation organizations to develop competencies associated with the SIM Practice Transformation Building Blocks as outlined within the Colorado SIM Framework and Milestones (see Attachment A). The building blocks are based on Thomas Bodenheimer’s, “The 10 Building Blocks of High Performing Primary Care.” The building blocks, which are made up of milestones, are aligned with alternative payment models to strengthen delivery of comprehensive primary care by moving toward greater integration of behavioral health services. Practice sites in Cohort 2 will qualify for SIM payments of up to $13,000 per practice site, and may apply for competitive grants up to $40,000. These practice transformation supports, among others, are designed to advance the delivery of person-centered, team-based care with an emphasis on integrated care.

Participation in SIM helps providers prepare for a changing healthcare landscape that has been shaped by the **Medicare Access and CHIP Reauthorization Act (MACRA)**, a bipartisan piece of legislation signed in 2015 that was designed to pay providers for the quality and effectiveness of the care they provide Medicare beneficiaries. Other payers have also implemented value-based payment models. This shift from volume-based to value-based payment puts the onus on practices to demonstrate higher-quality care that improves outcomes while reducing costs. Success in this value-based reimbursement world requires different skills and processes that allow providers to integrate behavioral health and primary care. The SIM Initiative helps guide practice sites along this path with intensive coaching to implement integrated care and turn data into actionable information that helps build sustainable models. Seven public and private payers signed a **Memorandum of Understanding (MOU)** with the SIM Office, in which they committed to work collaboratively with SIM to transform the way primary care and behavioral healthcare is delivered and financially supported in the practice sites selected for SIM within their networks.

**Eligibility:** Primary care practice sites in Colorado that use an electronic health record (EHR) are eligible to apply for this opportunity.
**Benefits:** Practice sites participating in SIM will receive multiple benefits, including:

<table>
<thead>
<tr>
<th>Area</th>
<th>Benefit</th>
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| **Practice Transformation Support Services** | • Practice facilitation:  
  o Access to support from a certified Practice Transformation Organization  
  o Preparation for new Medicare Quality Payment Program (QPP) and other initiatives that require a transition from fee-for-service to value-based payments  
  o Development of high functioning care teams within your practice using efficient workflows  
  o Implementation of your practice vision for integrating behavioral health into your primary care practice  
  • Technical support from a Clinical Health Information Technology Advisor (CHITA)  
  • Opportunities to earn Continuing Medical Education (CME) and Maintenance of Certification (MOC) credits  
  • Opportunity to learn from peers during twice-yearly Collaborative Learning Sessions with other SIM practice sites |
| **Financial Support** | • Opportunity to earn SIM payments of up to $13,000 per practice site for achieving milestones within key building blocks  
  • Opportunity to apply for competitive grants up to $40,000 to support behavioral health integration  
  • Practice sites are eligible to receive value-based payments from one or more SIM-participating private and public payers |
| **Recognition** | • Certificate of recognition signed by the Governor’s Office |
| **Health Information Technology** | • In-person technical support provided by a CHITA  
  • Support connecting to a health information exchange to share data and coordinate care  
  • Subsidies for nonprofit practice sites to install or upgrade broadband, a key step toward developing the infrastructure necessary to provide telehealth services |
| **Data** | • Access to aggregated claims data that allows cost and utilization data to be tracked across providers and payers to improve population health management  
  • Access to aggregated clinical quality data to compare practice site level data to the SIM cohort and inform quality improvement efforts |
| **Connections to Community Resources** | • Access to a Regional Health Connector (RHC), a local person dedicated to connecting practice sites to resources that can improve patient outcomes  
  • Connection to local public health resources and data related to population health |
| **Business Support** | • Access to data benchmarking to help practice sites assess business processes  
  • Training program to develop skills in budgeting and administrative processes to support value-based payments |
| **Patient Outcomes** | • Integrated behavioral healthcare produces significant positive results, including decreased patient depression levels, improved quality of life, decreased stress, and lower rates of hospitalization  
  • Having access to behavioral health services for patients is expected to reduce the total cost of care. Some studies indicate that integrated care leads to a reduction of inappropriate use of medical services and cost-savings in big-ticket items, such as emergency department visits and hospitalizations (see References at end of the document for citations) |
| **Provider Satisfaction** | • Integrated behavioral health services may improve patient and provider satisfaction by reducing access barriers, improving communication and enabling providers to influence comorbidities between physical and behavioral health issues |
Each practice will be supported by the following three roles, along with other resources:

<table>
<thead>
<tr>
<th>Practice Facilitators</th>
<th>Clinical Health Information Technology Advisors (CHITAs)</th>
<th>Regional Health Connectors (RHCs)</th>
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<td>Quality Improvement Coach Support</td>
<td>Technical and Data Processes Support</td>
<td>A Trusted Local Convener</td>
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<tr>
<td>• Develop practice leaders who support a culture of improvement</td>
<td>• Support practice data capacity</td>
<td>• Link practices to health care and social determinants of health resources in their communities and across the state</td>
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<tr>
<td>• Establish effective quality improvement teams</td>
<td>• Analyze and identify ways to improve practice data systems</td>
<td>• Listen for needs and opportunities</td>
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<tr>
<td>• Identify and solve problems</td>
<td>• Optimize workflows for data collection, reporting, and analysis</td>
<td>• Strengthen community capacity to address local health priorities</td>
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<tr>
<td>• Link practices to transformation resources</td>
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<td>• Develop relationships among providers, community partners, and local health systems</td>
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**Expectations:** Over the course of two years, SIM practice sites will work to achieve a set of milestones within the SIM Practice Transformation Building Blocks as outlined in the Colorado SIM Framework and Milestones (see Attachment A). These building blocks focus on testing alternative payment models, strengthening the delivery of comprehensive primary care, and moving toward greater integration of behavioral health services.

All participating practice sites will receive SIM Practice Transformation Program support and will be expected to meet requirements as outlined in the table on the following page. Additional detail can be found in the Expectation of SIM Participation for SIM-Only and SIM/CPC+ Practice Sites sections.

**Alignment with Comprehensive Primary Care Plus (CPC+):** SIM is collaborating with CMS to align SIM with CPC+, another initiative funded by CMS through the Centers for Medicare and Medicaid Innovation (CMMI) to strengthen primary care and help practice sites shift from volume-based to value-based payment systems. Practice sites currently participating in CPC+ are eligible and encouraged to participate in SIM. These complementary initiatives offer unique benefits to practice sites that are interested in integrating behavioral health and primary care. Practice sites that participate in both initiatives will receive support through the SIM Practice Transformation Program that will build on the support provided by CPC+. Support will focus on behavioral health integration, business support, and health information technology assistance.

In addition to meeting all requirements of the CPC+ initiative, practice sites that participate in both SIM and CPC+ must meet the expectations outlined in the table below. These expectations are slightly modified from those required of practices that participate in the SIM initiative alone. Expectations for CPC+ practices have been designed to reduce the burden of participating in two initiatives while enhancing outcomes beyond what would be expected as a result of participating in CPC+ alone.
SUMMARY OF SIM PARTICIPATION EXPECTATIONS

Shared Expectations of All SIM Practice Sites

1) Identify a cross-functional Quality Improvement Team to implement improvements based on the SIM Practice Transformation Building Blocks.

2) Complete a set of practice assessments to identify key areas of focus for improvement.

3) Participate in SIM evaluation activities.

<table>
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<tr>
<th>Expectations of Practice Sites Participating in SIM-Only</th>
<th>Expectations of Practice Sites Participating in CPC+ and SIM</th>
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<td>4) <strong>Required</strong> to attend the SIM Collaborative Learning Sessions.</td>
<td>4) <strong>Encouraged</strong> to attend the SIM Collaborative Learning Sessions, but not required to do so.</td>
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<tr>
<td>5) Collect, report, and review SIM Clinical Quality Measures on a quarterly basis (see Attachment B).</td>
<td>5) Collect, report, and review only those SIM Clinical Quality Measures that align with CPC+ requirements on a quarterly basis (see Attachment B).</td>
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<tr>
<td>6) Complete a foundational subset of building blocks through achievement of key milestones (see Attachment A; also outlined in Section II).</td>
<td>6) Complete an advanced subset of building blocks through achievement of key milestones (see Attachment A; also outlined in Section II).</td>
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** Practice sites that participate in both CPC+ and SIM will be expected to adhere to all expectations of CPC+.

SECTION I. Program Overview & Eligibility

SIM Background
The State of Colorado will receive up to $65 million under the State Innovation Model (SIM) Initiative to implement and test its State Health Care Innovation Plan. Colorado’s plan creates a system of clinic-based and public health supports to spur innovation. The state will improve the health of Coloradans by: (1) providing access to integrated primary care and behavioral health services in coordinated community systems; (2) applying value-based payment structures; (3) expanding information technology efforts, including telehealth; and (4) finalizing a statewide plan to improve population health. CMMI funding will help Colorado integrate physical and behavioral healthcare in more than 400 primary care practice sites and community mental health centers that comprise approximately 1,600 primary care providers. In addition, the state will work to establish partnerships between public health, behavioral health, and primary care sectors. Visit the Colorado SIM website for more information: www.ColoradoSIM.org.

Three cohorts of practice sites will participate in the Colorado SIM Initiative:

- **Cohort 1**: 100 practice sites began participating in SIM in February 2016. These practice sites will receive two years of transformation support.
• **Cohort 2**: Approximately 150 practice sites will be selected through this RFA. Practice sites will receive two years of transformation support beginning in fall of 2017.

• **Cohort 3**: The SIM Office anticipates that practice sites in this cohort will be selected in early 2018. The size of this cohort is anticipated to include approximately 150 practices, but may vary depending on the number of practice sites supported in Cohort 2. Practice sites in Cohort 3 will receive one year of transformation support.

Since there are ongoing changes in the practice transformation landscape, as reflected by CPC+ and other new initiatives, the SIM Office reserves the right to change the structure of these cohorts, including the number of practice sites accepted to each one.

The University of Colorado is issuing this RFA for primary care practice sites in Colorado that wish to participate in the second cohort of the SIM Initiative to receive support through the SIM Practice Transformation Program. The information that follows describes benefits to practice participation, expectations of participating practice sites, required and preferred characteristics for inclusion in the program, the application process, the review and selection process, and timelines for practice selection.

**Key Definitions**

**Practice**: For purposes of this RFA, a practice is defined as a “practice site or physical location.” A practice may have one tax identification number (TIN) that includes multiple providers in several locations, but for purposes of the SIM Practice Transformation Program, a “practice site” is defined as one physical location. For example, a practice with one TIN might have five locations; for this RFA, those sites are considered five “practice sites,” and each practice site must submit its own application. For the initial cohort, a desire to have a wide diversity of practice types resulted in a limitation on the number of accepted practice sites within a given healthcare group or system. For SIM Cohort 2, an effort will be made to accept as many qualified practice sites as possible in a group or system to help expedite transformation within the overall organization.

**Primary Care**: As defined by the Institute of Medicine (IOM), primary care is the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community.

An applicant primary care practice site must be capable of providing a majority of its patients’ comprehensive primary, preventive, chronic, and urgent care.

“Non-traditional” practice sites that provide a full range of primary care services and otherwise meet the requirements can be considered for participation. Non-traditional practice sites could include school-based clinics, local public health clinics, practice sites providing primary care services to specified groups of patients (such as women’s health clinics), and others.

Applicants that are not clearly traditional primary care practice sites but feel they provide primary care services will be considered on a case-by-case basis. On the application, “non-traditional” practice sites will be asked to address how the practice meets the IOM definition of primary care. Prior to review or acceptance, these practice sites might be required to provide additional information (such as billing information), to substantiate that they provide comprehensive primary care services.
If practice eligibility remains unclear after review of a practice site’s completed application, participation recommendations will be made by the Application Review Committee that is convened by the University of Colorado. Final decisions will be made by the SIM Office.

**Behavioral Health Care:** For SIM, the term “behavioral health care” includes the spectrum of services used to diagnose, prevent and manage substance use disorders, health behavior aspects of disease, and mental health.

**Practice Site Eligibility**
To be eligible for participation in SIM Cohort 2:
1. Practice sites must be physically located in Colorado.
2. Individual practice sites must complete and submit the application in its entirety online before 11:59 pm MST on March 31, 2017.
3. Practice sites must meet the IOM definition of primary care (outlined above).
4. Practice sites must currently use an EHR.

Healthcare systems/multi-site organizations or other sponsoring organizations interested in participating in SIM Cohort 2 should encourage their individual practice sites to apply and can assist practice sites in preparing their applications. Some sections within the application must be completed by the practice site; in particular, questions in narrative sections should be completed by a lead clinician or another key leader from the practice site.

**Advantages of SIM Participation**
In addition to monetary compensation and practice transformation support, there are many other benefits to practice sites participating in the SIM Practice Transformation Program, which include but are not limited to:

1. Benefits to patients that can improve Clinical Quality Measures (CQMs) and other indicators of practice performance, which can have an effect on practice success in alternative payment models, including:
   a. Integrated or collaborative behavioral healthcare produces significant positive results, including decreases in patient depression levels, improvement in quality of life, decreased stress and lower rates of hospitalization. \(^2\text{–}^5\)
   b. Improved access to behavioral health services is expected to reduce the total cost of care. Some studies indicate that integrated care leads to a reduction of inappropriate use of medical services and cost-savings in big-ticket items like emergency department visits and hospitalizations. \(^6\text{–}^9\)
   c. Integrated behavioral health services may improve patient satisfaction by reducing access barriers, improving communication and enabling providers to influence comorbidities between physical and behavioral health issues. \(^10\)

2. Benefits to providers from implementing an integrated model of care, as reported by primary care physicians, include: \(^5\)
   a. Better communication
   b. More comprehensive services
   c. Better management of depression, anxiety, and alcohol abuse
   d. More convenient services for patients
   e. Less stigma for patients
   f. Better coordination of mental and physical health
   g. Quicker appointments for mental health services
   h. Better health education
   i. These benefits improve provider satisfaction
3. Behavioral health screening, treatment and care coordination are essential components of advanced models of primary care and various advanced payment models.
4. Business consulting expertise provided through the SIM Practice Transformation Program will help practice sites prepare for value-based budgeting as they move from fee-for-service to value-based payments, bundled payments, and shared savings.
5. Clinical health information technology (HIT) support will help practice sites optimize their EHRs, create registry functionality, and generate better data to manage patient care including gaps in care, risk stratification, management of cost of care, care management, and care coordination.
6. Practice sites will gain access to peer-to-peer learning and sharing so they are not struggling on their own and reinventing what others have already figured out.
7. SIM practice sites will have access to SIM payments to practices to offset some of the costs associated with the requirements of participating in SIM.
8. Continuing Medical Education (CME) credits and eligibility for Part IV Maintenance of Certification (MOC) credit toward board recertification requirements will be offered.

Expectations of SIM Participation for SIM-Only Practice Sites
1. Identifying a cross-functional Quality Improvement Team to implement improvements based on the SIM Practice Transformation Building Blocks. This QI Team should be maintained throughout the duration of SIM and include representation from various roles within the practice. For most practice sites, this team will include a provider, office administrator, clinical support, and front desk staff. Depending on the practice, it might also include a behavioral health professional and/or a care manager.
   a. Dedicating time for the QI Team to meet with the Practice Facilitator up to twice a month for approximately one hour each time.
   b. Dedicating time as needed to work with a CHITA to develop and implement a Data Quality Plan (DQP) that will assist with practice data reporting and data-driven quality improvement.
2. Completing a set of practice assessments to identify key areas of focus for improvement. These baseline and periodic project assessments include the Integrated Practice Assessment Tool (IPAT), Medical Home Practice Monitor, and the Clinician and Staff Experience Survey that will help practices track progress over time. The practice site will also be expected to complete a Practice Improvement Plan (PIP) that identifies specific goals the practice intends to achieve throughout participation in SIM. An overview of assessments, including a timeline can be found in Attachment C.
3. Collecting, reporting and reviewing SIM Clinical Quality Measures (CQMs) on a quarterly basis. CQMs that will be collected, reported and reviewed are outlined in Attachment B.
   a. Based on their patient demographics, practice sites will be asked to select either the pediatric measure set or the adult measure set. Family and/or mixed practice sites can choose either one of the measure sets to report throughout their participation in SIM.
   b. SIM-Only adult practice sites will report a total of six required CQMs. SIM-Only pediatric practice sites will report a total of four required CQMs. Practice sites are encouraged but not required to report additional CQMs from a secondary measure set based on practice reporting ability and arrangements with payers.
4. Attending two regional Collaborative Learning Sessions per year. In a spirit of fostering a true peer-to-peer learning community, practice representatives may be asked to share insights through presentations and panel discussions at these sessions.
5. Participating in SIM evaluation activities. This includes completing baseline as well as periodic and end-of-project assessments. This process might also include key informant
interviews with TriWest, an organization contracted to conduct an evaluation of the SIM Initiative, and other evaluation-related requirements specified by TriWest or CMMI.

6. Completing SIM-Only identified building blocks through achievement of key milestones. The key milestones required for SIM-Only practices to receive SIM payments to practices are outlined in Section II and in the SIM Practice Transformation Building Blocks (see Attachment A; also outlined in Section II).

**Expectations of SIM Participation for SIM/CPC+ Practice Sites**

Practice sites that participate in both CPC+ and SIM will be expected to adhere to all expectations of CPC+, including: Undertaking care delivery transformation activities outlined in the Care Delivery Requirements established by CMS that are focused around five Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health.

Practice sites participating in both SIM and CPC+ will meet similar requirements as the SIM-Only practices, but the requirements have been tailored to closely align with existing CPC+ expectations. The requirements are as follows:

1. Identifying a cross-functional Quality Improvement Team to implement improvements based on the SIM Practice Transformation Building Blocks. This QI Team should be maintained throughout the duration of SIM and include representation from various roles within the practice. For most practice sites, this team will include a provider, office administrator, clinical support, and front desk staff. Depending on the practice, it might also include a behavioral health professional and/or a care manager.
   a. Dedicating time for the QI Team to meet with the Practice Facilitator up to twice a month for approximately one hour each time.
   b. Dedicating time as needed to work with a CHITA to develop and implement a Data Quality Plan (DQP) that will assist with practice data reporting and data-driven quality improvement.

2. Completing a set of practice assessments to identify key areas of focus for improvement. These baseline and periodic project assessments include the Integrated Practice Assessment Tool (IPAT), Medical Home Practice Monitor, and the Clinician and Staff Experience Survey that will help practices track progress over time. The practice site will also be expected to complete a Practice Improvement Plan (PIP) that identifies specific goals the practice intends to achieve throughout participation in SIM. An overview of assessments, including a timeline can be found in Attachment C.

3. Collecting, reporting and reviewing SIM Clinical Quality Measures (CQMs) that align with CPC+ requirements on a quarterly basis. Reporting on the practice-level measures established annually by CMS. Note that the CQMs reported for CPC+ will count for SIM, and no additional measures for SIM are required. CQMs that will be collected, reported, and reviewed are outlined in Attachment B.

4. Participating in CPC+ Learning System and activities. SIM/CPC+ practice sites are encouraged to attend the SIM Collaborative Learning Sessions, but are not required to do so.

5. Participating in SIM evaluation activities. This includes completing baseline as well as periodic and end-of-project assessments. This process might also include key informant interviews with TriWest, an organization contracted to conduct an evaluation of the SIM Initiative, and other evaluation-related requirements specified by TriWest or CMMI.

6. Completing SIM/CPC+ identified building blocks through achievement of key milestones. The key milestones required for SIM/CPC+ practices to receive SIM payments to practices
are outlined in Section II and in the SIM Practice Transformation Building Blocks (see Attachment A).

Overview of Practice Transformation Program Support
Practice sites will be provided with a practice facilitator and a CHITA and linked with a Regional Health Connector (RHC) to deliver a comprehensive, personalized package of in-office support that will allow practices to successfully realize SIM Initiative goals and connect them with community and state resources. The practice facilitator and CHITA will be provided by one or more practice transformation organizations (PTOs) selected by a rigorous procurement process to ensure that practice sites benefit from highly-skilled personnel. The RHC will be deployed through local organizations selected for their existing, trusted relationships in the communities they serve. An overview of each role is provided below:

1. Practice Facilitator Role:
   a. Support implementation of an ongoing change and quality improvement process through Quality Improvement Teams
   b. Contribute to the development and updating of a SIM Practice Improvement Plan (PIP)
   c. Facilitate Quality Improvement Team activities to focus on PIP objectives
   d. Identify and help resolve challenges in achieving objectives
   e. Facilitate the development of sustainable quality improvement techniques and processes
   f. Coordinate and facilitate practice site access to additional practice transformation resources, including coordination with the local RHC

2. CHITA Role:
   a. Assist in the development and updating of a SIM Data Quality Plan (DQA), including identification and assessment of current HIT resources
   b. Support the enhancement of practice capacity to implement data-driven quality improvement
   c. Assist with the development and implementation of practice workflow for data collection, reporting, validation and analysis
   d. Facilitate data-driven quality improvement priorities
   e. Link practice sites with technical assistance available through various SIM and non-SIM HIT resources

3. RHC Role:
   a. Provide information regarding state and regional transformation and community health resources
   b. Facilitate the connection of practice site to local public health and other community resources
   c. Establish ongoing supportive relationships with practice sites that can be sustained beyond the two years of active practice transformation support

4. Other activities included in the SIM Practice Transformation Program include:
   a. A baseline assessment to help practices identify strengths and opportunities for improvement using the SIM Practice Transformation Building Blocks as outlined within the Colorado SIM Framework and Milestones and based on Thomas Bodenheimer’s, “The 10 Building Blocks of High Performing Primary Care.”
   b. Facilitated development of a Practice Improvement Plan (PIP) with measurable goals and timelines
   c. Facilitation to implement the PIP using rapid cycle improvement methodology
   d. Developing and implementing a Data Quality Plan (DQP) that includes reporting and reviewing cost and quality measures
   e. Offering two peer-to-peer Collaborative Learning Sessions per year
   f. Processes to help practices adopt alternative payment models
g. Support moving toward greater integration of behavioral health care. Practice Transformation support will be tailored to each practice site’s unique needs and priorities via a model that is aligned with the CPC+ Behavioral Health Integration Menu of Options

**HIT Support**

Practice sites will be provided with the following resources related to HIT:

1. **Data Aggregation:** SIM practice sites will receive a license to a data aggregation tool that allows cost and utilization data to be tracked across providers and participating payers. This tool will allow practice sites to access data across the medical neighborhood, manage population health and integrate it with their clinical data, and view total cost of care.

2. **Broadband Subsidies:** Eligible practice sites will be connected to the Colorado Telehealth Network, which can help practices access federal telecom subsidies. Participants that access this support, on average, save 49 percent on their telecom spending. Eligible sites include nonprofit organizations that oversee the following:
   a. Hospitals
   b. Rural health clinics
   c. Local health departments
   d. Community safety net clinics and federally qualified health centers
   e. Health centers providing healthcare to migrant workers
   f. Post-secondary educational institutions offering healthcare instruction
   g. Teaching hospitals
   h. Medical schools
   i. Other nonprofit health care providers in a consortium

3. **Connection to Health Information Exchanges:** The SIM Office is currently pursuing avenues to help practice sites connect to health information exchanges and maximize data exchange with other clinicians and hospital systems. More information will be provided in the practice acceptance packet.

**Available Funding**

SIM practice sites can access the following funds to help advance practice transformation activities.

1. **SIM Payments to Practices:** Participating SIM-Only and CPC+/SIM practice sites are eligible to receive payments for completion of SIM Practice Transformation Program activities and achievement of key milestones within identified building blocks up to a total of $13,000, as outlined in the table below. Practice sites will submit invoices for payment and a list of milestones achieved within the identified building blocks at the end of each year of participation. See the SIM Payments to Practice Sites Table on the next page.
2. Small Grants via the Practice Transformation Fund: Participating SIM-Only and CPC+/SIM practice sites can apply for competitive grants of up to $40,000 to assist in meeting SIM milestones and achieving goals outlined in their Practice Improvement Plans. The Small Grants Program will be administered by the SIM Office. Funds for this opportunity are provided via a generous grant from The Colorado Health Foundation. Applicants will be selected through a competitive process based on the overall quality of the application, the likelihood that the project will help the practice achieve the practice transformation milestones, and practice need, including the needs of the practice’s target population and the demonstrated need for the project.

Support from Payers
In Colorado, public and private payers have voluntarily developed a multi-payer approach to support and expand broad-based accountable, whole person, patient-centered care transformation through a variety of initiatives. Within this landscape, seven payers signed a Memorandum of Understanding (MOU) with the SIM Office, in which they committed to work collaboratively with SIM to transform the way primary care and behavioral healthcare are delivered and financially supported in the practice sites selected for SIM within these networks. These payers are collaborating to:

1. Focus on primary care practice sites and behavioral health settings seeking to integrate care
2. Support providers in delivering and coordinating integrated care that improves population health, and increases quality while reducing costs
3. Increase providers’ abilities to manage whole-person care
4. Develop necessary infrastructure to support integration and delivery of whole-person care
5. Encourage practice sites to continually evolve towards higher-levels of integration through transformation of care delivery support by alternative payment models (APMs)

Payers participating in SIM have agreed to apply organization-specific payment model(s) and establish their own agreements with practice sites selected for SIM Cohort 2. Payers already have APMs in place with many practice sites in their networks to support primary care transformation. For
SIM, value-based payments received through a payer-specific APM will support practice site work around behavioral health integration.

Payers’ existing APMs are already tied to outcomes measures for each plan, and payers are working collaboratively to align their measures in support of behavioral health integration. Participating payers have aligned practice expectations to the SIM Practice Transformation Building Blocks. Payers’ payment methodologies are designed to support practice capacity and infrastructure to achieve the milestones within these building blocks during the course of the initiative. Additionally, payers have aligned around the SIM set of CQMs and claims-based measures that will help practice sites identify things that influence healthcare quality, utilization, and costs.

While each payer is using its own payment model to support SIM’s transformation goals, the payment model(s) that payers will apply to SIM participating practice sites include the following basic elements:

1. Fee-for-service payments
2. Payments that include behavioral health integration through one of the following mechanisms:
   a. Upfront payments
   b. Population-based payments (e.g., PMPM)
   c. Care coordination payments
   d. Payment for additional codes
3. Shared savings opportunities OR incentive payments based on performance and/or outcomes linked to quality

Selection for SIM practice transformation support DOES NOT guarantee that practice sites already receiving payment support from payers will receive any additional value-based payments for participation in SIM. As noted, payers are establishing their own agreements with practice sites and using different approaches that include:

1. Continuation of existing models/commitments: Some payers are continuing existing payment arrangements with practice sites that are already participating in APMs; this includes practice sites participating in other payer-specific or federal initiatives.
2. Extension of existing models/commitments to new practice sites: Some payers are extending the models used in current initiatives (e.g., CPC+, payer-specific programs/projects) to additional new practice sites participating in SIM.
3. Modification of existing models/commitments to include new funding: Some payers have modified the models used in current, ongoing initiatives to include new funding for progression through the practice transformation milestones outlined in the Colorado SIM Framework and Milestones.

The payment models that payers are applying to SIM practice sites are aligned with a continuum of APMs established by the Health Care Payment and Learning Action Network (HCPLAN), a national collaborative of public and private stakeholders working to accelerate the healthcare system’s adoption of effective APMs. Payers are using models within Categories 2 and 3 with an aim to evolve toward Category 4 methodologies during the course of the SIM Initiative. A copy of the HCPLAN framework, and a brief description of each SIM payer’s payment model, can be found in the Addendum to the MOU.

Colorado’s selection as a Round 1 CPC+ region provides additional opportunities and resources to support care delivery and payment reform efforts in the state, which are heightened by Medicare’s
participation as a payer. Primary care practice sites are eligible and encouraged to participate in CPC+ and SIM. However, initiatives that are designed to test or identify the most appropriate methods for using value-based payments, particularly those sponsored by CMS, are not intended to be additive to existing payment models. All eligible practice sites selected for CPC+ will receive payment support from payers participating in CPC+, per the requirements of the model. However, practice sites selected for CPC+ that are also selected for SIM Cohort 2 will likely not receive additional value-based payments for their participation in SIM, depending on the payer.

SECTION II. Colorado SIM Framework & Milestones

Overview of Milestones

The SIM Framework and Milestones (see Attachment A) are intended to be benchmarks that guide and measure where participating practice sites are in their transformation journeys. They build off the Bodenheimer Building Blocks and the Comprehensive Primary Care (CPC) initiative milestones and activities and reflect the priorities of SIM-participating payers. The milestones have been developed by the SIM Office, Multi-Payer Collaborative, and the University Practice Transformation Program to emphasize and support SIM’s focus on advancing behavioral health integration within comprehensive primary care settings.

The Colorado SIM Practice Transformation Building Blocks and their associated milestones are not application criteria, but rather a roadmap for where practice sites will be headed based on their participation in SIM. Practice sites should consider their commitment to achieving these benchmarks when determining whether to apply for the SIM Initiative.

Practice sites are expected to maintain “Good Standing” with the behavioral health focus of the initiative through successful completion of identified building blocks, through achievement of key milestones as outlined below. If practice sites are not in Good Standing with SIM, payers will individually determine the impact to their programs, which may affect the payment a practice receives from its payers. The SIM Office will work with practice transformation organizations and the University to support transformation and to determine a practice site’s standing. Practice standing information will be shared with payers to inform practice eligibility for payment from individual payers.

Practices must achieve identified building blocks through completion of key milestones to maintain “Good Standing.” Requirements to maintain “Good Standing” for each year are outlined below:

Practice Sites Participating in SIM-Only:

- **Project Year 1:**
  Practice sites must achieve Year 1 milestones within building blocks: 1, 2, 3, 4, and 7.

- **Project Year 2:**
  Practice sites must achieve Year 2 milestones within building blocks: 1, 2, 3, 4, 7, and any two additional building blocks.

Practice Sites Participating in SIM and CPC+:

- **Project Year 1:**
  Practice sites must achieve Year 1 milestones within building blocks: 1, 2, 3, 4, 7, 8, 9, and 10.

- **Project Year 2:**
  Practice sites must achieve Year 2 milestones within building blocks: 1, 2, 3, 4, 7, 8, 9, and 10.
SECTION III. Practice Application

Practice Application Instructions and Questions

Please note that to be considered for participation in Cohort 2, practice sites must complete the online application by the deadline of March 31, 2017 at 11:59 pm MST. Hard copy or emailed applications will NOT be accepted. For additional information, questions or concerns email PracticeTransformation@ucdenver.edu; call 303-724-8968.

The SIM Cohort 2 Application Instructions and Questions can be found in Attachment E of this document.

Practice Site Roster, Key Contacts, and NPIs
Applications with incomplete information in the Practice Site Key Contacts and Practice Site Provider Roster sections, including omitted National Provider Identifiers (NPIs), may be considered ineligible. Each participating practice is required to have five key contacts on file with SIM: Primary Practice Site Contact, Practice/Office Manager, Provider Champion, Lead Clinician/Provider, and HIT/EHR Contact. Additionally, including a Practice Contact for Payers or Insurance Companies will result in more direct communication between your practice and its payers, if applicable. The same person within a practice may fill multiple roles and can be listed as a Key Contact more than once. It is important that these practice contacts are accurate and up-to-date as specific SIM communications will be directed to the appropriate contact based on the information included in this section of the application. Accuracy of NPIs and Taxonomy Codes are important because cost and utilization data from the All-Payer Claims Database (APCD) is driven by accurate attribution of the right patients to the right providers, which begins with accurate NPIs.

SECTION IV. Practice Application Review & Selection Process

Overview of Practice Application Review
The University of Colorado will coordinate a comprehensive, thorough, complete and impartial review of each application received. An incomplete practice application may be disqualified and not considered for review if the required information is not provided.

All applications submitted in response to this RFA will be reviewed and evaluated by an Application Review Committee. Practice sites will be required to meet the basic eligibility criteria outlined in SIM Cohort 2 Practice Expectations specified in Attachment D. Practice sites will be evaluated and ranked based on meeting the required and preferred characteristics, and responsiveness of the application. A comprehensive list of all applications along with the committee evaluation and ranking will be provided to the SIM Office. The SIM Office will consider payer support and other factors that affect the overall diversity of the cohort (such as practice geography, size, type, and system representation) and will select practice sites for Cohort 2.

Application Review Committee
The Application Review Committee will be a multi-stakeholder review panel convened by the University of Colorado for the purpose of making a recommendation to the SIM Office regarding practice sites for Cohort 2 of the SIM Practice Transformation Program. The Application Review Committee will be comprised of subject matter experts who meet identified characteristics to ensure the integrity of the application evaluation process. The University of Colorado will adhere to
the following guiding principles in convening the review committee: ensuring there are no conflicts of interest among the reviewers regarding which practice sites are selected (including asking that reviewers who have conflicts to recuse themselves from discussions of specific practice sites), facilitating the independent review of applications, requiring that the evaluation be based strictly on the content of the application, and ensuring the fair and impartial treatment of all applicants. The size of this committee will be dictated by the number of practice applications received.

Application Review and Practice Selection Process
Applications will be screened using the published eligibility criteria. Practice sites will be expected to meet the eligibility criteria and required elements listed under the SIM Cohort 2 Practice Expectations in Attachment D.

The first level of review will be conducted by University staff to determine whether a practice site meets the eligibility criteria, including being a primary care practice in Colorado as defined by the IOM. "Non-traditional" primary care practice sites that otherwise meet the requirements will be reviewed by a committee convened by the University of Colorado and the SIM Office to determine if they meet the definition of primary care.

Recommendations regarding the ranking and mix of practice sites for the second SIM cohort will be determined at an in-person meeting of the reviewers and will be informed by the following process:

1. Each application will be assigned to a primary and secondary reviewer.
2. Each reviewer will be assigned to a set of applications and will be given a set of accompanying scoring sheets. Reviewers will use these scoring sheets to identify the required elements that have been met by the applicant and to assign the application points based on the degree to which the reviewer believes that the applicant meets the required and preferred elements. The point total is the “reviewer score,” which will be used to inform whether the practice site is recommended for participation in SIM.
3. The primary reviewer will present the case at the in-person meeting, and then the secondary reviewer will present any discrepancies in his/her assessment of the practice.
4. The group will then vote on assigning a practice to one of four categories:
   i. Strongly recommend
   ii. Recommend
   iii. Consider with some concerns
   iv. Do not recommend at this time
5. The reviewer score will be used to break ties when there are decisions about which practice sites should be included on the recommended list.

The SIM Office will make the final determination of which practice sites are included in Cohort 2 after considering payer support for each practice and elements needed to reach a diverse cohort of practice sites.
REFERENCES

SIM BUILDING BLOCK | YEAR-1 MILESTONES | YEAR-2 MILESTONES | GOAL
--- | --- | --- | ---
1 Engaged leadership that supports integration and change | • Practice has completed an annual budget that includes SIM revenue and planned expenses. 
• Practice develops a quality improvement (QI) team that meets monthly. 
• Practice leadership team presents at meetings and a clinical champion attends SIM Collaborative Learning Sessions. 
• Practice has vision for behavioral health integration and identifies pathway for behavioral health transformation that is signed by leadership. 
• Practice establishes value-based agreement(s) with payer(s) covering at least 150 patients. | • Leadership allocates appropriate resources to complete QI work. 
• Practice designs plan to evaluate effects of value-based payment agreements. | Practice establishes agreement(s) with payer organization(s) that cover at least 150 patients across payers, for value-based payment program(s) to support practice transformation. 

2 Practice uses data to drive change | • Practice successfully submits eCQMs quarterly. 
• Practice reviews data with PF/CHITA quarterly. 
• Practice begins using model for improvement; identifies opportunities for improvement using CQM data. 
• Practice begins using data aggregation tool to review cost and utilization data. | • Practice reviews eCQM data to inform rapid cycle improvement processes. 
• Practice develops processes for providing performance feedback to providers, including CQM, cost and utilization data. 
• Practice conducts regular PDSA/QI activities on identified CQMs. | Practice uses EHR clinical quality measures to run quarterly panel reports on all SIM measures not extracted through claims data; uses claims data from data aggregation tool to inform QI processes. 

3 Practice population is empaneled | • Practice has assessed patient panel and assigned PCPs/care teams to 75% of patient population. 
• Practice reviews payer attribution lists monthly. 
• Practice designs and implements process for validating PCP/care team assignment with patients. | • Practice maintains 75% empanelment of patients with provider/care teams. 
• Practice develops policies to support empanelment, including definitions, changing PCPs, assigning new patients, and ensuring continuous coverage. | Practice has and maintains patient empanelment for at least 75% of its population.
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<tr>
<th><strong>SIM BUILDING BLOCK</strong></th>
<th><strong>YEAR-1 MILESTONES</strong></th>
<th><strong>YEAR-2 MILESTONES</strong></th>
<th><strong>GOAL</strong></th>
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| 4 Practice provides team-based care | • Practice uses established tool to assess baseline team relationship.  
• Practice has written job descriptions.  
• Practice identifies, implements a team-based care strategy (team huddle, collaborative care planning). | • Practice re-evaluates team relationship using tool from Year 1.  
• Practice develops protocols for shared workflows for three quality measures (with at least one behavioral health measure).  
• Practice performs task distribution activity to inform development of team-based care P&Ps. | Care team uses shared operations, workflows, protocols to facilitate collaboration; consistently implements shared workflows vs. informal processes for at least three measures including at least one behavioral health measure. |
| 5 Practice has built partnership with patients | • Practice evaluates patient population to identify three preference-sensitive conditions (with at least one behavioral health condition) that are appropriate for decision-aids or self-management support tools.  
• Practice identifies, selects evidence-based decision-aids or self-management support tools for identified conditions.  
• Practice establishes a PFAC that meets at least quarterly. | • Practice identifies patients eligible for selected decision aids or self-management support tools.  
• Practice implements decision aids or self-management support tools and establishes protocol and workflow for use.  
• Practice develops process for tracking, evaluating use of decision-aids or self-management support tools.  
• Practice uses PFAC to evaluate care experience. | Practice uses evidence-based, shared decision-making aids or self-management support tools for at least three preference-sensitive conditions including at least one behavioral health condition, and tracks use of tools.  
Practice establishes a PFAC to provide input, feedback on practice transformation activities and progress. |
| 6 Practice actively manages patient population using data | • Practice identifies, documents a risk stratification methodology.  
• Practice identifies strategy to identify care gaps (e.g. patient registry, data aggregation tool). | • 75% of empaneled patients are risk-stratified.  
• 75% of high-risk patients have documented care plan.  
• Practice implements proactive care gap management; tracks outcomes.  
• Practice embeds care plan template in EHR. | Practice uses population-level data to manage care gaps, develop care management care plans and implement plans for high-risk patients. |
| 7 Practice links primary care to behavioral health and social services | • Practice identifies behavioral health resources for patients including health plan support from SIM participating plans.  
• Practice identifies a screening tool for reporting on at least two of the five behavioral health screening measures for SIM (depression, maternal depression, and substance use disorders); screens 25% of patients.  
• Practice has documented process for connecting patients with behavioral health resources including standing orders/protocols and follow-up. | • 50% of patients are screened for behavioral health condition(s).  
• Practice performs an assessment of community resources to assist patients with social needs (such as food, housing, transportation).  
• 50% of patients identified with behavioral health need are connected to resources. | Practice screens at least 90% of patients for substance use disorder/other behavioral health needs; includes behavioral health and community services as part of care management strategies. |
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| 8 Practice provides prompt access to care, including behavioral healthcare | • Practice representative has EHR access available 24 hours, 7 days per week.  
• Practice performs an assessment of referral pathways and available after-hours support for behavioral health.  
• Practice identifies data sources and technology needed for bi-directional data sharing. | • Practice establishes a collaborative agreement with at least one behavioral health provider.  
• Practice develops plan for bi-directional data sharing with behavioral health provider. | Practice, at a minimum, has established collaborative care management agreements with behavioral health providers in the community and members of the care team can articulate how to use those agreements.  
Practice has ability to share clinical data based on collaborative care management agreements with behavioral health providers bi-directionally within 7 days. |
| 9 Practice provides comprehensive care coordination for primary/behavioral healthcare | • Practice can identify total cost of care for patient panel and subset of patients with behavioral health conditions.  
• Practice identifies and implements policy and procedures that include timely follow-up for emergency department (ED) and hospital admissions. | • Practice contacts 50% of patients within 7 days of hospitalization or ED visit, including medication reconciliation.  
• Practice identifies cost drivers for patients with behavioral health condition and incorporates in QI processes.  
• Practice creates, reports a measurement to assess impact and guide improvement on at least one of the following:  
  □ Notification of ED visit in timely fashion  
  □ Medication reconciliation process completed within 72 hours  
  □ Notification of admission and clinical information exchange at the time of admission  
  □ Information exchange between primary care and specialty care related to referrals | Practice has reduced total cost of care while maintaining or improving quality of care for patients including those with depression and substance use disorders compared with non-SIM practices. |
| 10 Practice has fully integrated behavioral health care to provide whole-person care | • Practice identifies, documents referral pathway for behavioral health needs (including assessment of referral pathways and available after-hours support for behavioral health and a representative with EHR access available 24 hours, 7 days per week).  
• Practice develops a plan to systematically measure and track patient behavioral health outcomes.  
• Practice develops care plans that include patient actions to manage behavioral health conditions. | • Practice systematically measures and tracks patient behavioral health outcomes.  
• Practice documents and implements protocols to manage care provided to identify high-risk behavioral health populations.  
• Practice identifies and implements at least two opportunities to adjust its protocols to improve behavioral health status of patients. | Patient behavioral health outcomes are systematically measured over time and treatment is adjusted as needed, as measured by outreach, registry and other information readily available for purpose of monitoring and adjustment. |

*EHR: electronic health record  
• PF: Practice facilitator  
• CHITA: Clinical health information technology advisor  
• eCQM: electronic clinical quality measure  
• QI: quality improvement  
• PDSA: plan, do, study, act  
• PCPs: primary care providers

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| 1 Practice has engaged leadership, supportive of integration and change | • Practice has completed an annual budget that includes SIM revenue and planned expenses.  
• Practice develops quality improvement (QI) team and meets monthly.  
• Leadership present at meetings and clinical champion attends learning collaboratives.  
• Practice has vision for behavioral health integration, and has identified a pathway for behavioral health transformation signed by leadership.  
• Practice establishes agreement(s) with payer(s) covering at least 150 patients. | • Leadership allocates appropriate resources to complete QI work.  
• Practice designs plan to evaluate impact of value-based payment agreements. | Practice establishes agreement(s) with payer organization(s) that cover at least 150 patients across payers, for value-based payment program(s) to support practice transformation under SIM. |
| 2 Practice uses data to drive change | • Practice successfully submits eCQMs quarterly.  
• Practice reviews data with practice facilitator (PF)/clinical health information technology advisor (CHITA) quarterly.  
• Practice begins using model for improvement and has identified opportunities for improvement using CQM data.  
• Practice begins using a data aggregation tool to review cost and utilization data. | • Practice reviews eCQM and data from data aggregation tool to inform rapid cycle improvement processes.  
• Practice develops processes for providing performance feedback to providers, including CQM, cost, and utilization data.  
• Practice conducts regular PDSA/QI activities on identified CQMs. | Practice uses EHR clinical quality measures to provide quarterly panel reports on all SIM measures not extracted through claims data; uses claims data provided through a data aggregation tool to inform QI processes. |
| 3 Practice population is empaneled | • Practice has assessed patient panel and assigned primary care providers/care teams to 75% of patient population.  
• Practice reviews payer attribution lists monthly.  
• Practice designs and implements process for validating primary care provider/care team assignment with patients. | • Practice maintains 75% empanelment of patient population to provider or care teams.  
• Practice develops policies to support empanelment, including definitions, changing PCPs, assigning new patients, and ensuring continuous coverage. | Practice has, and maintains, at least 75% of its patient population empaneled. |
| 4 Practice provides team-based care | • Practice uses established tool to assess baseline team relationship.  
• Practice has written job descriptions.  
• Practice identifies and implements a team-based care strategy (e.g., team huddle, collaborative care planning). | • Practice reevaluates team relationship using tool from Year 1.  
• Practice develops protocols for shared workflows for three quality measures (with at least one behavioral health measure).  
• Practice performs task distribution activity to inform development of team-based care P&Ps | The care team uses shared operations, workflows, and protocols to facilitate collaboration and consistently implements specific shared workflows rather than informal processes for at least three measures, including at least one behavioral health measure. |
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| **5** Practice has built partnership with patients | • Practice evaluates patient population to identify one preference-sensitive condition that would be appropriate for decision-aids or self-management support tools.  
• Practice identifies and selects evidence-based decision-aids or self-management support tools for identified conditions.  
• Practice has established a patient and family advisory Committee (PFAC) and meets at least quarterly. | • Practice identifies patients/families that are eligible for selected decision aids or self-management support tools.  
• Practice implements decision aids or self-management support tools and establishes protocol and workflow for use.  
• Practice develops process for tracking and evaluating use of decision-aids or self-management support tools.  
• Practice uses PFAC to evaluate care experience. | Practice has established use of evidence-based shared decision-making aids or self-management support tools for at least one, preference-sensitive condition, and tracks the use of these tools.  
Practice has established a PFAC to provide input and feedback on practice transformation activities and progress. |
| **6** Practice is actively managing patient population using data | • Practice identifies strategy to identify care gaps (e.g. patient registry, data aggregation tool) and prioritize high-risk patients/families. | • 75% of high-risk patients/families have a documented care plan.  
• Practice implements proactive care gap management and tracks outcomes.  
• Practice embeds care plan template in EMR. | Practice uses population-level data to manage care gaps, develop care management care plans and institute those plans for high-risk patients/families. |
| **7** Practice has linked primary care to behavioral health and social services | • Practice has identified behavioral health resources for patients/families, including health plan support from SIM participating plans.  
• Practice has identified a screening tool for reporting on at least two of the five behavioral health screening measures for SIM (depression, maternal depression, and developmental screening) and screens 25% of patients.  
• Practice has documented process for connecting patients/families with behavioral health resources (from screening), including standing orders and/or protocols and follow-up. | • 50% of patients are screened for behavioral health condition(s).  
• Practice performs an assessment of community resources to assist patients/families with social needs (such as food, housing, transportation).  
• 50% of patients identified with behavioral health need are connected to resource. | Practice screens at least 90% of appropriate patients/families for substance use disorder and/or other behavioral health needs, and includes behavioral health and community services as part of care management strategies. |
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| 8  Practice provides prompt access to care, including behavioral healthcare | • Practice has representative with EMR access available 24 hours, 7 days per week.  
• Practice performs an assessment of referral pathways and available after-hours support for behavioral health.  
• Practice identifies data sources and technology necessary for bi-directional data sharing. | • Practice has established a collaborative agreement with at least one behavioral health provider.  
• Practice develops plan for bi-directional data sharing with behavioral health provider. | Practice, at a minimum, has established collaborative care management agreements with behavioral health providers in the community and members of the care team can articulate how to use those agreements.  
Practice has ability to share clinical data based on collaborative care management agreements with behavioral health providers bidirectionally within 7 days. |
| 9  Practice provides comprehensive care coordination for primary and behavioral healthcare | • Practice can identify total cost of care for patient panel, and subset of patients with behavioral health condition.  
• Practice identifies and implements policy and procedures that included timely follow-up for emergency department (ED) and hospital admissions. | • Practice contacts 50% of patients within 7 days of hospitalization or ED visit, including medication reconciliation  
• Practice identifies cost drivers for patients with behavioral health condition and incorporates in QI processes.  
• Practice creates and reports a measurement to assess impact and guide improvement on at least one of the following:  
  1. Notification of ED visit in timely fashion  
  2. Medication reconciliation process completed within 72 hours  
  3. Notification of admission and clinical information exchange at the time of admission  
  4. Information exchange between primary care and specialty care related to referrals | Practice has reduced total cost of care while maintaining or improving quality of care for patients, including those with depression, and substance use disorders compared with non-SIM practices. |
| 10 Practice has fully integrated behavioral healthcare to provide whole-person care | • Practice has identified and documented referral pathway for behavioral health needs (including assessment of referral pathways and available after-hours support for behavioral health and a representative with EMR access available 24 hours, 7 days per week).  
• Practice develops a plan to systematically measure and track patient behavioral health outcomes.  
• Practice develops care plans that include patient/family actions to manage behavioral health conditions. | • Practice systematically measures and tracks patient behavioral health outcomes.  
• Practice documents and implements protocols to manage care provided to identify high-risk behavioral health populations.  
• Practice identifies and implements at least two opportunities to adjust its protocols to improve behavioral health status of patients. | Patient behavioral health outcomes are systematically measured over time and treatment is adjusted as needed, as measured by outreach, registry and other information readily available for purpose of monitoring and adjustment. |

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ATTACHMENT B. SIM Clinical Quality Measure (CQM) Reporting Requirements

Primary vs. Secondary

- Primary measures are the focus areas where SIM aims to move the needle over the course of the initiative. Secondary measures are still important, and can be reported, but practice sites should focus their practice transformation and data quality efforts on the primary measures. Practice sites will make a good faith effort to report on all primary CQMs for SIM.
- If practice sites cannot report a primary CQM in a given quarter, the practice site should select a secondary CQM to report in its place. Practice sites should work with their Clinical Health Information Technology Advisor (CHITA) to report all primary CQMs in future quarters. Practice sites are encouraged to work with their CHITA to report on all SIM CQMs, including the secondary CQMs, over time and should phase them in as appropriate. Additionally, some payers may ask for secondary CQMs as part of their APM contracts with practices, and practices should work with their CHITAs to understand specific payer reporting requirements and submit those for SIM.

Measurement Period

- Practice sites will report using a trailing year measurement period. If this is not possible, practice sites will report using a year-to-date (YTD) measurement period. For more information, please see this guidance: http://www.practiceinnovationco.org/wp-content/uploads/2017/01/Changing-SIM-CQM-measurement-period.pdf
- For Q4 reporting, practice sites should submit clinical quality measure data from the full calendar year January 1 – December 31 (note, trailing year and YTD measurement period are identical for reporting periods ending December 31 of a given year). This annual CQM report will be shared with payers who support your practice.

SIM Practice Sites Participating in CPC+

- Where applicable, CPC+ measures will count for SIM reporting. SIM will require CPC+ practice sites to choose the behavioral health measures within each of the 3 CPC+ reporting groups. CPC+ practices are not required to report any additional CQMs for SIM, unless they do not report the SIM measures within CPC+ reporting groups.
- CPC+ practice sites will report metrics in SPLIT for SIM in addition to any required reporting for CPC+ through the CPC+ submission portal or MIPS submission portal. All SIM participating practice sites, including CPC+ practice sites, will report CQMs quarterly for SIM, which will facilitate their preparations for the annual CPC+ report.
### SIM Clinical Quality Measure Set

*Specifications and guidance found in [SIM CQM Guidebook](#).*

#### Adult Measure Set

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<thead>
<tr>
<th>Measure Condition</th>
<th>SIM Metric Title</th>
<th>Citation</th>
<th>CPC+</th>
<th>QPP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary CQMs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan</td>
<td>NQF 0418 CMS 2v6</td>
<td>Depression Remission at 12 Months (can report for SIM)</td>
<td>✓</td>
</tr>
<tr>
<td>Diabetes: Hemoglobin A1c</td>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
<td>NQF 0059 CMS 122v5</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Controlling High Blood Pressure</td>
<td>NQF 0018 CMS 165v5</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Obesity: Adult</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan</td>
<td>NQF 0421 CMS 69v5</td>
<td>No obesity measure (not required for SIM if in CPC+)</td>
<td>✓</td>
</tr>
<tr>
<td>Substance Use Disorder: Alcohol and Other Drug Dependence</td>
<td>Initiation &amp; Engagement of Alcohol &amp; Other Drug Dependence Treatment</td>
<td>NQF 0004 CMS 137v5</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Substance Use Disorder: Tobacco</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>NQF 0028 CMS 138v5</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Secondary CQM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>Medication Management for People with Asthma</td>
<td>NQF 1799 CMS n/a</td>
<td>No asthma measure</td>
<td>✓</td>
</tr>
<tr>
<td>Fall Safety</td>
<td>Falls: Screening for Future Fall Risk</td>
<td>NQF 0101 CMS 139v5</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Maternal Depression</td>
<td>Maternal Depression Screening</td>
<td>NQF 1401 CMS 82v4</td>
<td>No maternal depression measure</td>
<td>✓</td>
</tr>
<tr>
<td>Substance Use Disorder: Alcohol</td>
<td>Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling</td>
<td>NQF 2152 CMS n/a</td>
<td>Alcohol &amp; Other Drug Dependence measure <em>(above)</em></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Measures reported via APCD claims data automatically</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Breast Cancer Screening</td>
<td>NQF 2372 CMS 125v5</td>
<td>✓ <em>(clinical)</em></td>
<td>✓ <em>(clinical)</em></td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>Colorectal Cancer Screening</td>
<td>NQF 0034 CMS 130v5</td>
<td>✓ <em>(clinical)</em></td>
<td>✓ <em>(clinical)</em></td>
</tr>
</tbody>
</table>
# Pediatric Measure Set

<table>
<thead>
<tr>
<th>Measure Condition</th>
<th>Metric Title</th>
<th>Citation</th>
<th>QPP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary CQMs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan</td>
<td>NQF 0418 CMS 2v6</td>
<td>✓</td>
</tr>
<tr>
<td>Development Screening</td>
<td>Developmental Screening in the First Three Years of Life *(developed by Mathematica)*</td>
<td>NQF 1448 CMS – under development</td>
<td></td>
</tr>
<tr>
<td>Maternal Depression</td>
<td>Maternal Depression Screening</td>
<td>NQF 1401 CMS 82v4</td>
<td>✓</td>
</tr>
<tr>
<td>Obesity: Adolescent</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>NQF 0024 CMS 155v5</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Secondary CQM</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>Medication Management for People with Asthma</td>
<td>NQF 1799 CMS n/a</td>
<td>✓</td>
</tr>
</tbody>
</table>

**CPC+ CQMs (that count for SIM)**

<table>
<thead>
<tr>
<th>Measure Condition</th>
<th>Metric Title</th>
<th>Citation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>Depression Remission at Twelve Months *(OR SIM depression measure above)*</td>
<td>NQF 0710 CMS 159v5</td>
</tr>
<tr>
<td>Diabetes: Hemoglobin A1c</td>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
<td>NQF 0059 CMS 122v5</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Controlling High Blood Pressure</td>
<td>NQF 0018 CMS 165v5</td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall Safety</td>
<td>Falls: Screening for Future Fall Risk</td>
<td>NQF 0101 CMS 139v5</td>
</tr>
<tr>
<td>Substance Use Disorder: Alcohol and Other Drug Dependence</td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
<td>NQF 0004 CMS 137v5</td>
</tr>
<tr>
<td><strong>Group 3</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Use Disorder: Tobacco</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>NQF 0028 CMS 138v5</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>Breast Cancer Screening *(SIM reported via claims)*</td>
<td>NQF 2372 CMS 125v5</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>Colorectal Cancer Screening *(SIM reported via claims)*</td>
<td>NQF 0034 CMS 130v5</td>
</tr>
</tbody>
</table>
## ATTACHMENT C. SIM Cohort 2 Assessments and Timeline

<table>
<thead>
<tr>
<th>Assessment Tools</th>
<th>Purpose</th>
<th>Who Fills it Out</th>
<th>Responsible for Reporting</th>
<th>Timing</th>
<th>Expected Time to Complete (Minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Home Practice Monitor</strong></td>
<td>Practice self-assessment of level of implementation of core aspects of advanced primary care</td>
<td>Practice Team led by PF</td>
<td>Practice Champion</td>
<td>Baseline &amp; Annually</td>
<td>60</td>
</tr>
<tr>
<td><strong>IPAT (Integrated Practice Assessment Tool)</strong></td>
<td>Assesses current methods BHI along levels of coordination, co-location and integration</td>
<td>Practice Champion</td>
<td>Practice Champion</td>
<td>Baseline &amp; Annually</td>
<td>10</td>
</tr>
<tr>
<td><strong>Clinician and Staff Experience Survey</strong></td>
<td>Individual provider and staff survey that assesses two subscales - Clinician and Staff Experience and Burnout</td>
<td>All Members of the Practice</td>
<td>Each practice member</td>
<td>Baseline &amp; Annually</td>
<td>15</td>
</tr>
<tr>
<td><strong>SIM Milestone Activity Inventory</strong></td>
<td>Assesses practice's current implementation of SIM milestone activities, helps identify gaps and prioritizes practice's next steps</td>
<td>Practice Team led by PF</td>
<td>Practice Team submits draft, PF submits final</td>
<td>Baseline &amp; every 6 months</td>
<td>60</td>
</tr>
<tr>
<td><strong>Data Quality Assessment</strong></td>
<td>Assesses practice's current state of data quality including accuracy of data element capture, validity of CQM reports and desired next steps for HIT</td>
<td>Practice HIT Champion led by CHITA</td>
<td>CHITA</td>
<td>Baseline &amp; Annually</td>
<td>60</td>
</tr>
<tr>
<td><strong>Practice Improvement Plan</strong></td>
<td>SMART goals related to practice transformation as it relates to milestone activities; Can be done at same time as inventory</td>
<td>Practice Team led by PF</td>
<td>PF</td>
<td>Baseline &amp; every 6 months</td>
<td>15</td>
</tr>
<tr>
<td><strong>Clinical Quality Measures</strong></td>
<td>Track patient and process outcomes achieved by practices</td>
<td>Practice Champion</td>
<td>Practice Champion</td>
<td>Every calendar quarter</td>
<td>Variable</td>
</tr>
</tbody>
</table>
ATTACHMENT D. SIM Cohort 2 Practice Expectations

Practice sites must complete an online application to be considered for engagement in SIM practice transformation activities. Applications will be screened using the proposed eligibility criteria and recommendations from the payers. Practice sites will be expected to meet the eligibility criteria and all of the required elements listed under “Practice Requirements & Preferences”. In the case of having more than 150 eligible practice sites interested in participating in Cohort 2, preferred elements will help determine which practice sites will be most likely to achieve SIM deliverables.

Practice Site Eligibility

1. Practice sites must be physically located in Colorado.
2. Individual practice sites must complete and submit the application in its entirety online before 11:59 pm MST on the posted deadline date.
3. Practice sites must meet the definition of primary care.
   a. Primary care, as defined by the Institute of Medicine (IOM), is the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.
   b. An applicant primary care practice must be capable of providing a majority of their patients’ comprehensive primary, preventive, chronic, and urgent care.
   c. “Non-traditional” practice sites that provide a full range of primary care services and otherwise meet the requirements can be considered. This could include school-based clinics, local public health clinics, practice sites providing primary care services to specified groups of patients (such as women’s health clinics), and others. Applicant practice sites that are not clearly traditional primary care practice sites but representatives believe they provide primary care services will be considered on a case-by-case basis and may be required to provide additional information (such as billing information) to substantiate that they provide comprehensive primary care services. Decisions on eligibility in such cases will be made by a committee convened by the University and the SIM Office.
4. Practice sites must use an EHR system.

Healthcare systems/multi-site organizations or other sponsoring organizations interested in participating in SIM Cohort 2 should encourage their individual practice sites to apply and can assist practice sites in preparing their applications. Some sections within the application must be completed by the practice site; in particular, questions in narrative section should be completed by a lead clinician or another key leader from the practice site.

Expectations of SIM Participation for SIM-Only Practice Sites

1. Identifying a cross-functional Quality Improvement Team to implement improvements based on the SIM Practice Transformation Building Blocks. This QI Team should be maintained throughout the duration of SIM and include representation from various roles within the practice. For most practice sites, this team will include a provider, office administrator, clinical support, and front desk staff. Depending on the practice, it might also include a behavioral health professional and/or a care manager.
   a. Dedicating time for the QI Team to meet with the Practice Facilitator up to twice a month for approximately one hour each time.
   b. Dedicating time as needed to work with a CHITA to develop and implement a Data Quality Plan (DQP) that will assist with practice data reporting and data-driven quality improvement.
2. Completing a set of practice assessments to identify key areas of focus for improvement. These baseline and periodic project assessments, include the Integrated Practice Assessment Tool (IPAT), Medical Home Practice Monitor, and the Clinician and Staff Experience Survey that will help practices track progress over time. The practice site will also be expected to complete a Practice
Improvement Plan (PIP) that identifies specific goals the practice intends to achieve throughout participation in SIM. An overview of assessments, including a timeline can be found in Attachment C.

3. Collecting, reporting and reviewing SIM Clinical Quality Measures (CQMs) on a quarterly basis. CQMs that will be collected, reported and reviewed are outlined in Attachment B.
   a. Based on their patient demographics, practice sites will be asked to select either the pediatric measure set or the adult measure set. Family and/or mixed practice sites can choose either one of the measure sets to report throughout their participation in SIM.
   b. SIM-Only adult practice sites will report a total of six required CQMs. SIM-Only pediatric practice sites will report a total of four required CQMs. Practice sites are encouraged but not required to report additional CQMs from a secondary measure set based on practice reporting ability and arrangements with payers.

4. Attending two regional Collaborative Learning Sessions per year. In a spirit of fostering a true peer-to-peer learning community, practice representatives may be asked to share insights through presentations and panel discussions at these sessions.

5. Participating in SIM evaluation activities. This includes completing baseline as well as periodic and end-of-project assessments. This process might also include key informant interviews with TriWest, an organization contracted to conduct an evaluation of the SIM Initiative, and other evaluation-related requirements specified by TriWest or CMMI.

6. Completing SIM-Only identified building blocks through achievement of key milestones. The key milestones required for SIM-Only practices to receive SIM payments to practices are outlined in Section II and in the SIM Practice Transformation Building Blocks (see Attachment A).

**Expectations of SIM Participation for SIM/CPC+ Practice Sites**

Practice sites that participate in both CPC+ and SIM will be expected to adhere to all expectations of CPC+, including: Undertaking care delivery transformation activities outlined in the Care Delivery Requirements established by CMS that are focused around five Comprehensive Primary Care Functions: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health.

Practice sites participating in both SIM and CPC+ will meet similar requirements as the SIM-Only practices, but the requirements have been tailored to closely align with existing CPC+ expectations. The requirements are as follows:

1. Identifying a cross-functional Quality Improvement Team to implement improvements based on the SIM Practice Transformation Building Blocks. This QI Team should be maintained throughout the duration of SIM and include representation from various roles within the practice. For most practice sites, this team will include a provider, office administrator, clinical support, and front desk staff. Depending on the practice, it might also include a behavioral health professional and/or a care manager.
   a. Dedicating time for the QI Team to meet with the Practice Facilitator up to twice a month for approximately one hour each time.
   b. Dedicating time as needed to work with a CHITA to develop and implement a Data Quality Plan (DQP) that will assist with practice data reporting and data-driven quality improvement.

2. Completing a set of practice assessments to identify key areas of focus for improvement. These baseline and periodic project assessments include the Integrated Practice Assessment Tool (IPAT), Medical Home Practice Monitor, and the Clinician and Staff Experience Survey that will help practices track progress over time. The practice site will also be expected to complete a Practice Improvement Plan (PIP) that identifies specific goals the practice intends to achieve throughout participation in SIM. An overview of assessments, including a timeline can be found in Attachment C.
3. Collecting, reporting and reviewing SIM Clinical Quality Measures (CQMs) that align with CPC+ requirements on a quarterly basis. Reporting on the practice-level measures established annually by CMS. Note that the CQMs reported for CPC+ will count for SIM, and no additional measures for SIM are required. CQMs that will be collected, reported and reviewed are outlined in Attachment B.

4. Participating in CPC+ Learning System and activities. SIM/CPC+ practice sites are encouraged to attend the SIM Collaborative Learning Sessions, but are not required to do so.

5. Participating in SIM evaluation activities. This includes completing baseline as well as periodic and end-of-project assessments. This process might also include key informant interviews with TriWest, an organization contracted to conduct an evaluation of the SIM Initiative, and other evaluation-related requirements specified by TriWest or CMMI.

Completing SIM/CPC+ identified building blocks through achievement of key milestones. The key milestones required for SIM/CPC+ practices to receive SIM payments to practices are outlined in Section II and in the SIM Practice Transformation Building Blocks (see Attachment A).
ATTACHMENT E. SIM Cohort 2 Application Instructions and Questions

Overview, Instructions & Resources
SIM Cohort 2 Application

Overview:
Thank you for your interest in the Colorado State Innovation Model (SIM) Initiative and interest in applying for SIM Cohort 2. By completing this online application [Practice Name] is demonstrating interest in participating in SIM Cohort 2. Please note all completed applications will be reviewed by a multi-stakeholder review committee that will provide recommendations to the Colorado SIM Office who will make the final selection of practices offered the opportunity to participate in SIM Cohort 2 anticipated to begin in September 2017.

Instructions: (Abbreviated)
The SIM Cohort 2 Application consists of nine sections:

- Practice Site Information
- Practice Site Demographics
- Practice Site Key Contacts
- Practice Site Provider Roster
- Health Information Technology (HIT)
- Practice Transformation
- Practice Site Narratives
- Participation Attestation
- Application Completion Status

The SIM Cohort 2 Application should be completed at the Practice Site level and reflect the demographics, key contacts, and information unique to [Practice Name].

Additional information regarding SIM can also be found at the University of Colorado Practice Innovation website: http://www.practiceinnovationco.org/sim/

For technical and programmatic questions related to this application please contact: PracticeTransformation@ucdenver.edu

PRACTICE SITE INFORMATION
This section collects basic information regarding the Practice Site and Practice Site Healthcare System or Multi-Site Organization (if applicable). Not all questions are required, but Practice Sites are encouraged to complete as much information as possible in order to create a more comprehensive practice profile.

COMPREHENSIVE PRIMARY CARE PLUS (CPC+) PARTICIPATION
1) Is this Practice Site participating in CPC+ this year?
1a) Practice Site’s CPC+ Application Number (if known):

PRACTICE SITE NAME(S)
Please confirm the Practice Site Name(s) below. Some fields have auto-populated based on your previous responses. Please modify where appropriate. The Official Practice Site Name is the formal name, and often the same as the Legal Practice Name. The Preferred Practice Name is the name the Practice Site would like used in SIM communications.

2) Enter Practice Site Names:
2a) Official Practice Site Name
2b) ‘Doing Business As’ (DBA) Name
2c) Preferred Practice Site Name
2d) Legal Practice Site Name(s)

PRACTICE SITE ADDRESS & PHONE NUMBER(S)
Please enter information regarding the Practice Site address and contact information.

3) Practice Site Physical Address:
4) Practice Site Phone Numbers:
**PRACTICE SITE BILLING & IDENTIFICATION INFORMATION**

Please enter information regarding the Practice Site: Billing Contact Information, Taxpayer Identification Number (TIN), Medicaid Billing ID Number(s), and Practice National Provider Identifier (NPI) for this Practice Site.

5) Is the Practice Site Billing Address and/or Phone Number different than the Practice Site Physical Address and Phone Number?
   5a) Practice Billing Address:
   5b) Practice Billing Phone Numbers:
6) What TINs will this Practice Site use to bill services in the practice?
7) Please list the Medicaid Billing IDs this Practice Site uses for Medicaid primary care services.
8) Practice Site Group National Provider Identifier (NPI):

**HEALTHCARE SYSTEM OR MULTI-SITE ORGANIZATION INFORMATION**

Please indicate if this Practice Site is a part of a Healthcare System or Multi-Site Organization. If applicable complete the additional fields below.

9) Does this Practice Site belong to a larger Healthcare System or Multi-Site Organization?
   9a) Healthcare System or Multi-Site Organization Name:
   9ai) Please specify the ‘Other’ Healthcare System or Multi-Site Organization Name:
   9b) Healthcare System or Multi-Site Organization Address:
   9c) Healthcare System or Multi-Site Organization Phone Numbers:

**PRACTICE SITE DEMOGRAPHICS**

This section collects basic demographics regarding the Practice Site and the Practice Site Healthcare System or Multi-Site Organization, if applicable. Practice Sites are encouraged to complete as much information as possible in order to create a more comprehensive practice profile.

10) Which of the following best describes this Practice Site's Organizational Structure?
    Federal (Veterans Administration, Department of Defense, etc.)
    Federally Qualified Health Center or Look-Alike
    Freestanding Urgent Care Center
    Health Maintenance Organization (e.g. Kaiser Permanente, etc.)
    Hospital or Health System Owned
    Mental Health Center
    Non-Federal Government Clinic (e.g. State, County, City, etc.)
    Primary Care Residency Practice
    Private Solo or Group Practice Public Health Service
    Rural Health Clinic School-Based Clinic
    Other (Specify)
10a) Please specify 'Other' Practice Site Organizational Structure:
11) Which of the following describes this Practice Site type?
    Family Medicine
    General Internal Medicine
    Primary Care
    Pediatrics
    Nurse-Led
    Primary Care
    School-Based Clinic
    Non-Traditional (Specify)
    Other (Specify)
11a & b) If this Practice Site is a 'Non-Traditional' or 'Other' Primary Care it must still meet
the Institute of Medicine (IOM) definition of primary care, “Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” An applicant primary care Practice Site must be capable of providing a majority of its patients’ comprehensive primary, preventive, chronic, and urgent care.
Please describe how this Practice Site meets the Institute of Medicine (IOM) definition of primary care as outlined above.

12) Is this Practice Site engaged in training future primary care practitioners and staff?
12a) Describe this Practice Site's training engagement below.
13) Has this Practice Site ever employed or contracted a Behavioral Health Professional?
14) Total number of Practice Site Providers with NPIs:

PRACTICE SITE PATIENT POPULATION
Please complete all questions regarding this Practice Site's patient population by entering estimates for each. Percentage totals must add up to 100%.

15) Total number of patient visits per year at this Practice Site:
16) Percentage of patients in this Practice Site in the following age ranges: 0-17 / 18-64 / 65+
17) Percentage of patients in the following payer categories for this Practice Site:
   Approximate % of Medicare
   Approximate % of Medicaid/CHIP
   Approximate % of Commercial or Private Insurance
   Approximate % with No Insurance
   Approximate % of Other Payer Category
18) Please indicate if your Practice Site meets any of the following formal designations for serving underserved populations:
   Federally Qualified Health Center or Look-Alike
   Rural Health Clinic
   Indian Health Services Center
   Colorado Indigent Care Program
   Community Safety Net Clinic
   Health Profession Shortage Area
   Other (Specify)
   Not Applicable

18a) Please specify 'Other' formal designations for serving underserved populations:

PRACTICE SITE KEY CONTACTS
This section aims to collect necessary information regarding [Practice Name] Key Contacts and Healthcare System or Multi-Site Organization Contacts, if applicable. Practices are encouraged to fill out this section as completely and accurately as possible.

PRACTICE SITE & MULTI-SITE ORGANIZATION KEY CONTACTS
Please provide information regarding Key Contacts for this Practice Site. As an individual may fill multiple roles within a Practice Site, they can also be identified in more than one key contact role.

19a) Primary SIM Practice Site Contact
19b) Practice/Office Manager
19c) Provider Champion
19d) Lead Clinician/Provider
19e) HIT/EHR Contact
19f) Contact for Payers or Insurance Companies
19g) Healthcare System or Multi-Site Organization Contact

PRACTICE SITE PROVIDER ROSTER
This section aims to collect necessary information regarding the Practice Site's Providers. Practice Sites are required to include roster information for their Providers. This information can help determine if this Practice Site is eligible for additional financial support from payers participating in SIM. Please include all Providers at this Practice Site who have an NPI.

20) For each Primary Care Provider at the Practice Site enter the following:
   First Name, Last Name, Email, Provider/Staff Category, NPI, and Taxonomy Code.
ELECTRONIC HEALTH RECORD (EHR) SYSTEM
21) Please provide the following details regarding this Practice Site’s Electronic Health Record (EHR).
21a) Practice Site EHR
21b) EHR Version
21c) EHR Vendor

CENTER FOR MEDICARE AND MEDICAID SERVICES (CMS) INITIATIVES & MEANINGFUL USE
Please answer the following questions regarding participation in CMS Initiatives and attestation on Meaningful Use.

22) Does this Practice Site participate in CMS federal quality initiatives?
22a) Please specify which CMS federal quality initiatives this Practice Site participates in?
23) Have Providers at this Practice Site attested to Meaningful Use?
23a) Please indicate the highest Stage of Meaningful Use achieved.

CLINICAL QUALITY MEASURES (CQMs)
24) Is this Practice Site currently able to report SIM CQMs per the timeline outlined in the SIM CQM Reporting Requirements (Attachment B within the RFA document).
24a) (if not) What resources does this Practice Site need to develop in order to report SIM CQMs?

PRACTICE TRANSFORMATION
This section collects details about the Practice Site’s participation in Practice Transformation activities.

25) Has this Practice Site previously applied to participate in SIM?
26) Has this Practice Site participated in non-fee-for-service payments in the 24 months?
26a) Please identify which non-fee-for-service payments this Practice Site has participated in.
27) Over the past five years, had this Practice Site participated in any quality improvement or Practice Transformation activities with Practice Facilitators and/or Quality Improvement Coaches?
27a) Please list the quality improvement Practice Transformation activities this Practice Site has participated in the last five years.
28) Is this Practice Site recognized as a Patient-Centered Medical Home?
28a) Please indicate the organization that recognizes this Practice Site as a ‘Medical Home’
28ai) Specify the standard year for National Committee for Quality Assurance (NCQA-PCMH):
28aii) Specify State-Based Recognition Program name and recognition level received:
28aiii) Specify the recognition level received for Utilization Review Accreditation Commission (URAC):
28aiiv) If ‘Other’ please specify.

PRACTICE NARRATIVES
This section provides the opportunity for Practice Sites to share their practice transformation goals and reasons for applying to the SIM Initiative. Please answer each question thoroughly and distinctively for this Practice Site.

29) Explain why this Practice Site is interested in participating in SIM, and identify the benefits anticipated from participation in SIM.
30) Describe this Practice Site’s Leadership, Provider and Staff commitment to Practice Transformation. Please discuss how Leadership will support transformational change and identify resources required for sustainable change. Include any quality improvement or practice transformation activities that the Practice Site has participated in the last five years.
31) Identify the existing or planned processes this Practice Site has for supporting behavioral health integration.
32) Please provide any additional information you would like us to consider or any comments you would like to share.

SIM PARTICIPATION ATTESTATION
The section below documents the Practice Site’s attestation to the accuracy of the information provided in the SIM Cohort 2 Application and an understanding of the general expectations of participation in SIM.

The attestation below is NOT a commitment to participate in SIM. Practice’s selected for SIM Cohort 2 will have the opportunity to accept or decline participation after the offer.

33) By signing this application to be considered for participation in SIM Cohort 2, this Practice Site attests:
a. Practice Leadership and/or Healthcare System or Multi-Site Organization Leadership, supports the intention to move toward increasing integrated primary care and behavioral health.
b. The SIM Cohort 2 Application was completed by the staff and/or providers at the Practice Site with approval of the Healthcare System or Multi-Site Organization, if applicable.
c. Commitment to participate in two years of practice transformation and agrees to:
   - Identify a cross-functional Quality Improvement Team to implement improvements
   - Complete a set of practice assessments to identify key areas of focus for improvement
   - Collect, report, and review SIM Clinical Quality Measures on a quarterly basis
   - Attend two Collaborative Learning Sessions per year and/or for CPC+ participating practices, participate in CPC+ Learning System and activities
   - Participate in SIM evaluation activities
   - Achieve selected SIM building blocks through achievement of key milestones
d. This Practice Site has the ability and willingness to account for funding received from SIM
e. This Practice Site has the ability and interest to participate in alternative payment models such as Per Member Per Month (PMPM), Bundled Payments, Global Payments, Shared Savings

Please provide the name of the person attesting to the statements above:
34) Please provide the name of the person submitting this application for this Practice Site:
35) In addition to the person identified in Question 34, Practice Sites can enter up to three additional contacts to receive an email confirming the submission of a SIM Cohort 2 Application for [Practice Name.] Application Contact: