Colorado State Innovation Model (SIM)
Practice Transformation Toolkit
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Building Block 1: Engaged Leadership

Institute for Healthcare Improvement (IHI): High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs

This white paper presents three interdependent dimensions of leadership that together define high-impact leadership in health care: New Mental Models, High-Impact Leadership Behaviors, and IHI High-Impact Leadership Framework.

Activity B

AHRQ Integration Academy

The AHRQ Academy web portal offers resources to advance the integration of behavioral health and primary care, and fosters a collaborative environment for dialogue and discussion among relevant thought leaders.

SAMHSA Standard Framework for Levels of Integrated Care

This issue brief reviews levels of integrated healthcare and proposes a functional standard framework for classifying sites according to these levels.

Safety Net Medical Home Initiative: Behavioral Health Integration Implementation Guide

This guide walks through the steps of identifying a vision for behavioral health integration, pathways to successful implementation, monitoring progress, then spreading and sustaining integration successes.

PCMH eLearning Module: Leadership Skills

Effective leadership in the PCMH requires a different model and approach - leadership is shared, less hierarchical, and focuses on managing and leading change. This module discusses how to develop skills for shared leadership, effective ways to lead the change process and methods for sustaining the PCMH within your practice.

SIM eLearning Module: Introduction to Behavioral Health Integration

This module describes approaches and evidence for supporting behavioral health and primary care integration. Administrators, clinicians and staff are invited to complete module activities alone, together, or with the Quality Improvement Coach.
Activity B

A Guide to Creating and Using a Budget

This guide walks through the process of prospective budgeting to prepare for potential alternative payment methodologies in practice.

Budget Benchmarking Tool and Year to Date Budget Worksheet Instruction

A supplemental document to support the Year to Date Budget Worksheet for practices to use when benchmarking budgetary goals.

Year to Date Percent of Budget Worksheet

This tool helps practices set and benchmark budgetary goals.

Building Block 2: Data Driven Improvement Using Computer-Based Technology

Activity A

BB2 Activity A Step 1-2

HealthIT.gov Practice Transformation Toolkit

The Practice Transformation Toolkit (Toolkit) is a downloadable, comprehensive set of tools and resources that providers and staff members can use to implement a new or upgraded electronic health record (EHR) in order to transform and improve their practice in the areas of operations, clinical quality, finances, and staff and patient satisfaction.

eLearning Modules: Health Information Technology

The HIT eLearning Modules are funded by the Colorado Department of Public Health and Environment and include four modules, each taking about 30 minutes to complete. You will receive AAFP CME credits for completing all four modules.

Activity B

BB2 Activity B Steps 1-2


IHI: Plan-Do-Study-Act (PDSA) Worksheet

This worksheet walks practices through the Plan-Do-Study-Act quality improvement cycle and methodology.
Quality improvement includes developing and implementing processes to improve both the process of patient care, patient safety, and patient outcomes. This module describes quality improvement models that have been shown to be effective for improving processes of patient care, discusses the use of quality improvement tools and provides quality improvement tools that can be utilized in the office setting.

**Activity C**

**BB2 Activity C Step 1**

AHRQ on Practice-Based Population Health: Information Technology to Support Transformation to Proactive Primary Care

This report describes the concept of Practice-Based Population Health and the information management functionalities that may help primary care practices to move forward with this type of proactive management.

**BB2 Activity C Step 3**

AHRQ: Using Health Information Technology to Support Quality Improvement in Primary Care

*White paper emphasizing the importance of utilizing ongoing quality improvement activities, such as feedback and data, to track and assess primary care redesign performance.*

**Activity D**

**BB2 Activity D Step 1**

AHRQ Practice Facilitation Handbook: Module 7. Measuring and Benchmarking Clinical Performance

This module provides guidance on assisting practices to identify the clinical performance areas they want to assess in an effort to improve clinical process and patient outcomes.

**Building Block 3: Empanelment**

**Activity A**

**BB3 Activity A Step 1**

Safety Net Medical Home Initiative: Implementation Guide for Empanelment

Step-by-step instructions for assigning and managing panels and strategies for sustaining the effort over time. It discusses change concepts, offers a background,
roles and responsibilities of team members, pre-empanelment work, steps to empanelment, case studies, analyzing panel size and ongoing monitoring and adjusting of empanelment.

American Academy of Family Physicians- Panel Size: How Many Patients Can One Doctor Manage

Article discusses how to determine the number of patients a physician can effectively care for. This article provides a template for calculating current and ideal panel size. This worksheet is downloadable as an Excel version.

BB3 Activity A Step 3

Safety Net Medical Home Initiative- Addressing Staff Pushback for Empanelment

Discusses provider and manager push back examples, what the response should be and the management opportunity. It is a five page tool.

Activity B

BB3 Activity B Steps 1-2

Rocky Mountain Health Plans Community Brief 2(2): Predict, Prioritize, Prevent

Nine things practices should know about risk stratification and panel management.

Safety Net Medical Home Initiative- Examples of Scripting for Appointment Scheduling

Example scripts for scheduling appointments.

Safety Net Medical Home Initiative- Sample Primary Care Provider Assignment Policy

Policy example to guide primary care practices on what to do if an existing patient is unassigned, if a patient requests a PCP change, PCP requests that a patient be assigned to another provider and provides an example of a PCP Change Request Form.

Building Block 4: Team-Based Care

Activity A

BB4 Activity A Step 1

Primary Care Team Guide: The Practice Team
A practice assessment tool to evaluate the distribution of patient care tasks by role to help sites measure how well their primary care practice teams are functioning.

**Share the Care Assessment**

A practice assessment tool to determine the distribution of tasks within a practice, which can assist with role and responsibility definition among staff and providers.

**PCMH eLearning Module: Team Approach to Care**

A team approach to patient care is one cornerstone of the PCMH. This module describes how to build effective team-based patient care, discusses how team-based care improves patient outcomes and improves office efficiency and discusses how team-based care decreases health care costs.

**BB4 Action Step 1**

**Primary Care Team Guide**

This guide outlines the eight action steps for building effective care teams.

**Safety Net Medical Home Initiative Implementation Guide: Continuous and Team-Based Healing Relationships- Improving Patient Care through Teams Implementation**

This implementation guide addresses why care teams are important for improving patient care and ways to build an effective care team that meet patients’ needs and expectations.

**Cambridge Health Alliance Model of Team-Based Care**

An implementation guide and toolkit to support team-based care in primary care practices.

**Share the Care Assessment of Team Roles and Tasks**

**BB4 Activity A Step 2**

**Continuous and Team-Based Healing Relationships: Improving Patient Care through Teams**

This implementation guide provides guidance on how practices can develop and sustain strong care teams.

**Continuous and Team-Based Healing Relationships Resources**

This website offers links to implementation guides, tools, and webinars related to how to improve patient care through effective team-based care.

**Continuous and Team-Based Healing Relationships Supplement: Elevating the Role of the Medical/Clinical Assistant**
This supplement provides a curriculum and training materials (PowerPoint presentations, handouts, skill assessments, exams, etc.) that practices can use to enhance the skills of Medical and Clinical Assistants.

**Core Principles & Values of Effective Team-Based Healthcare**

Institute of Medicine (IOM) article discussing the principles and values of team-based care. The paper is intended to provide common reference points to guide coordinated collaboration among health professionals, patients, and families—ultimately helping to accelerate professional team-based care.

**BB4 Action Step 2**

**Roles and Responsibilities Diagram**

A diagram to use when determining the roles and responsibilities of Patient Advocates, Medical Assistants and Registered Nurses in the teamlet care model.

**Primary Care Team Guide- The Medical Assistants**

Rethinking the way Medical Assistants are utilized in primary care practices.

**Elevating the Role of the Medical/Clinical Assistant: Maximizing Team-Based Care in the Patient-Centered Medical Home**

An implementation guide supporting care teams as a critical element of transforming a practice into a patient-centered medical home (PCMH).

**Primary Care Team Guide- The Registered Nurse (RNs)**

A guide including action steps on utilizing RNs in effective ways within primary care.

**Role of the Behavioral Health Specialist**

Sample of a job description for a behavioral health consultant in primary care.

**Role of Clinical Pharmacist**

A summary and action steps of utilizing clinical pharmacist in primary care to improve patient care and ensure patients take their medications appropriately and safely.

**Activity B**

**BB4 Activity B Step 1**

**Fostering Partnership and Teamwork in the Pediatric Medical Home: A "How-to" Video Series**

These videos from the National Center for Medical Home Implementation show pediatric practices how to create efficiency through team huddles, build a stronger medical home through family advisory groups, and enhance collaboration with
families through care partnership support. The videos provide strategies, benefits and guidance on implementation in a practice setting.

**Key Elements of Highly Effective Teams**

Peer reviewed article which features a framework for effective team-based care which can be applied in pediatric practices.

**Science of Improvement: Forming the Team**

Detailed information from the Institute of Healthcare Improvement (IHI) regarding effective teams for improvement in health care. Includes examples which can be replicated in practice.

**Team-Based Care and the Pediatric Medical Home**

Examples of how to implement team based care into the pediatric medical home model. Provides links to other resources.

**BB4 Activity B Step 2**

**HealthTeamWorks Huddle Up!**

Information on brief daily meetings and how they keep the care team informed and focused on patient service.

**SAMHSA Huddles: Increased Efficiency in Mere Minutes a Day**

**Integration of Standing Orders into the Patient-Centered Medical Home Approach: A Community Health Center Provider Perspective**

**PCMH eLearning Module: Access to Care**

**BB4 Activity C Step 1**

**Achieving a Shared Plan of Care with Children and Youth with Special Health Care Needs with Children and Youth with Special Health Care Needs**

A shared plan of care endorsed by the American Academy of Pediatrics.

**Adult Care Plan Examples:**

NICHQ Care Plan Template

RMHP Care Plan Template

**Pediatric Care Plan Examples:**
AAP Pediatric Care Plan Template
Pediatric Shared Care Plans
NICHD Care Plan Templates

**Activity 2 Action Step 3**

**American Medical Association Implementation of a Daily Team Huddle**
An online module and tools to assist with developing consistent and effective daily huddles.

**Healthy Huddles**
Tools for establishing healthy huddles in primary care practices.

**SNMHI Implementation of Team-Based Care: Cambridge Health Alliance Model of Team-Based Care**
Guide for practices to use while building patient care teams.

**BB4 Action Step 1**

**Primary Care Team Conceptual Diagram**
A conceptual diagram that assists practices organize a care team around patients.

**The Teamlet Model of Primary Care**
An article addressing how practices can establish a small team (teamlet) care model to enhance patient experience.

**BB4 Action Step 6**

**Standing Orders and Protocols**
Guidelines for establishing and executing standing orders for non-clinical staff to allow patient care to be shared among clinical and non-clinical staff members.

**Primary Care Team Guide- Examples of Protocols and Standing Orders**
Examples of standing orders and protocols for both clinical and non-clinical staff members within primary care clinics.
Building Block 5: Patient-Team Partnership

Activity A

Community Health Association of Mountain/Plains States (CHAMPS) Patient Self-Management Tools

Self-Management Tools for asthma (Spanish), depression, CVD, diabetes, hypertension, weight, etc.

Depression Self-Management and Depression Self-Care Action Plan

Self-Management Tools from the HealthTeamWorks website.

Improving Chronic Illness Care: Critical Tools

Self-Management Tools for chronic disease.

Rethinking Drinking (NIH-NIAAA)

Online and free printed materials for patient self-management along the continuum of unhealthy alcohol use.

The Pain Toolkit

Self-management for chronic pain.

University of Michigan Depression Center: Depression Self-Management eLearning Module: Self-Management Support

Over 70% of patients who present in a primary care office have one or more chronic conditions. As such, clinicians are challenged with empowering these patients to become informed about their conditions and take an active role in their treatment. This module describes several patient-centered counseling techniques, methods for engaging patients with their healthcare and provides tools for goal-setting and action planning.

Activity B

BB5 Activity B Steps 1-2

AHRQ: Implementing Shared Decision Making In Varied Practice Settings

Webinar on Implementing Shared Decision Making in Varied Practice Setting.

AHRQ: SHARED Approach Curriculum Tools
Link to the PDF versions of the Shared Decision Making Workshop Tools.

Dartmouth-Hitchcock: Center for Shared Decision Making

Center for Shared Decision Making with links to toolkits.

Healthwise: Tap the Power of Shared Decision Making

Website that discusses shared decision making and a link that leads to shared decision making resource library.

Shared Decision Making — the Pinnacle of Patient-Centered Care

New England Journal of Medicine article on patient-team partnership.

Activity C

BB5 Activity C Steps 1-2

BJC Healthcare Patient and Family Advisory Councils

Step by step guide to creating patient advisory councils.

Institute for Patient and Family Centered Care: Creating Advisory Councils

Fact sheet to developing a patient advisory council.

Patient Satisfaction Survey

Step by step guide to carrying out a patient satisfaction survey. Tool funded by Bureau of Primary Health Care.

PCMH eLearning Module: Patient and Family Centered Care

Patient and family-centered care is the foundation of the Patient-Centered Medical Home (PCMH) and redefines the relationships in health care by placing an emphasis on collaborating with patients, at all levels of care, and in all health care settings. This module introduces the learner to the key concepts of patient and family-centered care, provides examples from patient and clinician perspectives of what it means to receive and provide patient and family-centered care, reviews several articles on this topic and provides a framework for assessing if your practice is providing patient and family-centered care.
Building Block 6: Population Management

Activity A

BB6 Activity A Step 1

Risk Stratification Methods for Identifying Care Coordination Patients

Article outlining the different risk stratification methods for identifying patients that would benefit from care coordination.

Risk Status Assignment Guide

BB6 Activity A Steps 2-3

Draft Fiscal Year 2016 ICD-10 Crosswalk Information Regarding Hierarchical Condition Categories

HHS-HCC risk adjustment model uses diagnosis codes in the current year to predict medical and drug spending in the same year. The diagnostic classification system underlying the HHS-operated risk adjustment model begins by mapping all ICD-9-CM diagnosis codes to diagnostic groups, or DXGs, and then maps the DXGs to hierarchical condition categories (HCCs). This article discusses how the HCC codes will transition from ICD-9 to ICD-10.

Preliminary ICD-10 CM Mappings for Hierarchical Condition Categories

This tool provides a spreadsheet showing the crosswalk mapping of HCC codes in ICD-9 to ICD-10.

Activity B

BB6 Activity B Steps 1-3

Care Coordination Measurement Tool (CCMT) for Pediatric Patients

Use of the CCMT enables measurement of the activities of care coordination, the necessary resources to implement those activities, and the resulting outcomes. By assessing both resource allocation and outcomes, the CCMT is an important tool enabling assessment of value in health delivery models. In multiple sites across the United States, it has been adapted for use in pediatric and adult delivery systems, in both ambulatory and inpatient settings.

Pediatric Care Coordination Curriculum

These modules created by Boston Children's Hospital provide participants with an overview of the steps involved in developing, evaluating and adapting a care coordination model that will be endorsed and supported by their organizations for use in delivering comprehensive, continuous, longitudinal care.
**Training Guide for the Care Coordination Measurement Tool (CCMT) for Pediatric Patients**

Care Coordination is a critical component of high quality and safe health care delivery. It is especially important for Children and Youth with Special Health Care Needs (CYSHCN) and for people of any age with chronic health conditions. This training manual provides the background knowledge for using the CCMT to measure the activities of care coordination.

**Complex Care Management Toolkit**

A guide to improving and implementing a complex care management program for individuals with multiple chronic conditions, limited functional status, and psychosocial needs, who account for a disproportionate share of health care costs and utilization.

**Activity C**

**BB6 Activity C Steps 1-2**

**CDC Alcohol Vital Signs**

Background information on the burden of disease attributed to alcohol use above a lower risk level in adults. Includes information on lower risk drink limits for men and women.

**CDC Planning and Implementing Screening and Brief Intervention for Risky Alcohol Use: A Step by Step Guide**

**Center for Adolescent Substance Abuse Research CeASAR and CRAFFT Adolescent Screening Tool**

Adolescent Substance Use Screening and Brief Intervention. Access the CRAFFT screening tool in multiple languages.

**Colorado Department of Public Health and Environment (CDPHE) Retail Marijuana Public Health Advisory Committee Clinical Guidelines and Resources**

Resources to prepare practices for identifying and utilizing intervention to reduce harms of marijuana use in adults, prevent use in adolescents, and prevent accidental exposure in children.

**Edinburgh Postnatal Depression Scales (EPDS) User Guide - English Version**

Free validated screening tool for pregnant women, postpartum mothers, adolescent mothers, and fathers/partners. Available in Spanish and English.

**Edinburgh Postnatal Depression Scales (EPDS) - Spanish Version**

**Guidelines for Adolescent Depression in Primary Care (GLAD-PC)**
The GLAD-PC Toolkit helps primary care providers to put the adolescent depression screening guidelines into effect. This toolkit was developed with the input of experts from the areas of adolescent depression, primary care behavioral medicine, parent and family advocacy, guideline development, and quality improvement.

**Pregnancy-Related Depression Clinical Guideline**

Clinical guideline developed by the Colorado Department of Public Health and Environment (CDPHE) and HealthTeamWorks.

**Screening, Brief Intervention, Referral and Treatment (SBIRT): A Step-by-Step Guide for Screening and Intervening for Unhealthy Alcohol and Other Drug Use**

**SBIRT Colorado Lower Risk Drinking Poster**

Poster for clinical settings that summarizes lower risk alcohol limits and standard serving sizes for adult alcohol screening and brief intervention.

**SBIRT Colorado Pocket Card**

Guide to screening and brief intervention for alcohol and drugs in adults and adolescents. Includes steps to providing a brief intervention.

**TeenScreen Primary Care Preparing Your Office Guide**

Guide to preparing your office for implement adolescent mental health checkups

**Video: A Rethink of the Way We Drink**

Short overview of the alcohol and health. Excellent background on why alcohol should be routinely addressed in healthcare.

**Activity D**

**BB6 Activity D Steps 1-3**

**AAFP Registries Made Simple**

Article outlining how to utilize a registry for population management.

**AAP Population Management Strategies**

AAP website provides links to patient population management tools to help in monitoring and anticipating the health care needs of patients as a group. Includes links to pediatric care plans, emergency plans, and asthma registry templates.

**AIMS CENTER: Excel Registry Tool**

PowerPoint educates on how to utilize Microsoft Excel to build a registry for tracking patients and their outcomes over time.

A guide to the design, implementation, analysis, interpretation and evaluation of the quality of a registry for understanding patient outcomes. This handbook describes the natural history of disease, helps to determine clinical effectiveness or cost effectiveness of health care products and services, and teaches to monitor safety and harm and to measure quality of care.

**PCMH eLearning Module: Population Management I**

Population management is becoming an important part of not just the PCMH, but also an important part of future reimbursement models. This module provides an introduction to population management, discusses the basics of building patient registries and describes the use of registries in primary care.

**Building Block 7: Continuity of Care**

**Activity A**

**Safety Net Medical Home Initiative- Continuous and Team-Based Healing Relationships: Improving Patient Care through Teams**

Guide for team-based care and applying continuity of care.

**Defining and Measuring Interpersonal Continuity of Care**

This article reviews the literature and summarizes several ways people define and measure continuity of care.

**Building Block 8: Prompt Access to Care**

**Activities A & B**

**Enhanced Access: Extending Care Services to 24 hours/7 days a week**

Webinar describing how to ensure prompt access to care.

**Moderator: Donna Daniel, PhD, Qualis Health. Speakers: L. Gordon Moore, MD, Ideal Medical Practices (Seattle, WA); Soma Stout, MD, Revere Family Health Center at Cambridge Health Alliance (Boston, MA)**

**Enhanced Access: Providing Care Patients Need, When They Need It**

Implementation Guide provides strategies and tactics practices can use to enhance patient access by eliminating barriers to care, balancing supply and demand, and creating capacity to provide care in real-time.

**Institute for Healthcare Improvement: Primary Care Access**
Provides tools for predicting periods of high and low demand.

**PCMH eLearning Module: Access to Care**

Access to care is one of the key tenants of the PCMH, yet can be difficult to attain in busy and multi-dimensional residency practices. This module discusses the challenges of developing open access scheduling, describes how to determine patient panel size and provides a curriculum developed by the Society of Teachers of Family Medicine on e-visits.

**Building Block 9: Comprehensiveness and Care Coordination**

**Activity A**

**BB9 Activity A Step 1**

**American College of Physicians: Referral Tracking Guide**

This document on the American College of Physicians Practice Improvement and Innovation website lays out the goals and mechanics of referral tracking.

**California Department of Public Health: Early Childhood Information Sharing Toolkit**

Example of a referral and follow-up form.

**Referral Workflow Example**

**BB9 Activity A Step 2**

**Cambridge Health Alliance-Union Square Family Health: Care Coordinator Job Description**

**Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms**

White paper from AHRQ on coordinating care in the medical neighborhood.

**Federal Expert Work Group on Pediatric Subspecialty Capacity: Promising Approaches for Strengthening the Interface between Primary and Specialty Pediatric Care**

Guide outlines promising referral practices, consultation approaches, and collaborative management approaches between pediatric subspecialties and primary care practices.
Wright Center for Primary Care with the Safety Net Medical Home Initiative: Closing the Loop with Referral Management

A power point presentation on referral management in practice.

**Activity B**

**BB9 Activity B Step 1**

**Care Collaborative Agreement Facilitation Guide**

Guide offers examples of agreements between primary care and specialty practices, providing background information and templates.

**American College of Physicians: High Value Care Coordination Toolkit**

Sample care coordination/care compact agreements.

**Colorado Patient-Centered Primary Care Collaborative: Colorado Primary Care–Specialty Care Compact**

Contains definitions, outlines types of care management transitions, provides points for mutual agreement, and provides expectations for primary and specialty care in terms of access, transitions, collaborative management, and patient communication.

**National Center for Medical Home Implementation- Coordinated Care**

Example of a co-management letter and a co-sharing agreement among patient (children)/families, Primary Care Physicians (PCP) and Specialists. This resource provides an example template of what a care compacts/collaborative agreements in the Pediatric Medical Home may look like.

**Safety Net Medical Home Initiative- Implementation Guide for Care Coordination**

Implementation Guide defines the difference and similarities in care management and care coordination, discusses the MacColl care coordination model, shares elements of effective case studies and touches on care coordination with health information technology.

**BB9 Activity B Step 2**

**Overcoming Barriers to Collaboration among Providers- Dayna Matthew, JD**

Integrating behavioral health and primary care requires many changes in practice including an understanding of how to share data across providers. This webinar will
discuss strategies for sharing information among behavioral health and primary care providers with the legal aspects being discussed. The goal of this webinar is to help dispel myths around sharing information across providers and offering up recommendations for what practices can do around sharing information.

**Activity C**

**BB9 Activity C Step 1**

**AHRQ: Re-Engineered Discharge (RED) Toolkit**

The Re-Engineered Discharge (RED) aims to effectively prepare patients and families for discharge from the hospital, improve patient and family satisfaction, and decrease hospital readmission rates. The post discharge follow-up phone call, the 12th component of the RED, is an essential part of supporting the patient from the time of discharge until patient's first follow-up care appointment.

**The Post-Hospital Follow-Up Visit: A Physician Checklist to Reduce Readmissions, the California HealthCare Foundation**

A checklist and background on post-hospital follow-ups and readmissions.

**PCMH eLearning Module: Integrated and Coordinated Care**

**Building Block 10: Template of the Future**

**Activity A**

**SAMHSA Standard Framework for Levels of Integrated Care**

This issue brief reviews levels of integrated healthcare and proposes a functional standard framework for classifying sites according to these levels.

**AHRQ Integration Academy**

The AHRQ Academy web portal offers resources to advance the integration of behavioral health and primary care, and fosters a collaborative environment for dialogue and discussion among relevant thought leaders.

**Activity B**

**American Medical Association: Guide to Physician-Focused Alternative Payment Models**
Better care for patients, financially viable physician practices, lower spending for payers.

**Brookings Institute: The Beginner’s Guide to New Health Care Payment Models**

Payment reform in health care is confusing, but the goal is simple: How can health care providers change their economic incentives to encourage value over volume?

**The Center for Health Care Quality and Payment Reform**

A useful website for implementing alternative payment models As part of the Medicare and CHIP Reauthorization Act of 2015.

**Activity C**

**California Integrated Behavioral Health Project**

Provides tools for implementing behavioral health in medical home settings and bi-directional health homes.

**Local Public Health and Environment Resources**

Reference to access activities and resources available from Local Public Health Agencies across the state of Colorado.

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**Correspondence**

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