PCMH and the Care of Complex High Cost Patients

15th Annual International Summit on Improving Patient Care in the Office Practice and the Community
March 10, 2014
Session A8/B8

Lucy Loomis, MD, MSPH, FAAFP
Pete Gutierrez
Jessica Johnson-Simmons, MPA
Jessica T. Lee, MHS

Session Objectives

• Demonstrate a model for application of PCMH requirements to high cost high risk populations
• Identify practice redesign concepts to integrate the care of this high risk population and the medical home
• Describe the effectiveness of a multidisciplinary care coordination model for addressing and managing the needs of high cost complex patients

These presenters have nothing to disclose
Community Health Services

- Network of 8 Community Health Centers, 15 School-based Health Centers, Urgent Care
- 406,000 visits in 2013
- Underserved population:
  - 36% uninsured, balance primarily Medicaid
- Resident training in almost all services but not all sites
- Integrated medical record and clinical registries
The mission of the Shingo Prize is to create excellence in organizations through the application of universally accepted principles of operational excellence, alignment of management systems and the wise application of improvement techniques across the entire organizational enterprise. We do this by teaching appropriate roles and accountabilities throughout the organization. **Shigeo Shingo distinguished himself as one of the world's leading experts in improving manufacturing processes.**
Improvement Culture

NQOA Recognition - PCMH

Health care that revolves around you
An Established Model of Care Coordination
Lean and PCMH, 21st Century Care

Built on the Framework of PCMH
21st Century Care Grant Overview

DH’s 21st Century Care builds on Patient Centered Medical Home (PCMH) and provides enhanced Health Information Technology (HIT)/clinical staffing tailored to patient risk/need:

- DH received largest CO innovation challenge grant ($19.8 million)
- One of 107 grantees out of nearly 3000 applicants
- Formal agreement between Denver Health and CMS to stage a test of a care delivery model
- This grant further positions DH as an innovator poised to influence the direction of delivery system transformation nationally

Lab and Test Tracking RIE
January 23 – 26, 2011

- Steve Kolpak, MD, Team Lead
- Jay H. Lee, MD, Process Owner
- Darlene Daskulak, RN
- Rossinda Diaz, HCP II
- Claudia Mendez, Clerk
- John Niemann, patient board member
- Angela Stepney, Lab Tech
- Lori Kaufman, PA
- Nancy McDonald, Assistant Director of LEAN

Solution Approach

<table>
<thead>
<tr>
<th>Action</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create a standard so that follow-up is done within one week.</td>
<td>We can improve patient safety and quality.</td>
</tr>
<tr>
<td>Utilize a weekly “missed/keep” e-mail alert notification system.</td>
<td>HCPs can reschedule missed appointments for imaging</td>
</tr>
<tr>
<td>Use the addendum function to link the follow-up plan to the patient encounter.</td>
<td>Documentation of follow-up will be easier to locate</td>
</tr>
<tr>
<td>Keep the written order for plain x-rays as a “tickler”.</td>
<td>We will close the loop and track plain x-rays that have not been completed</td>
</tr>
</tbody>
</table>
CHS Referral Tracking RIE

Date: March 28 – 31, 2011

Team
- Tammy Chasteen – Team Lead
- Darlene Datkulak – Process Owner
- Michael Benavidez
- Janice Tucker
- Pat Koller
- Nadia Perez
- Danielle LaCobe
- Fred “Frank” Kampe – Lean Facilitator

Consultants
- Paul Melnikovich
- Stephanie Hufbbs
- Patrick Hurley
- Marc Blasi
- Andrew Steele
- Lucy Loomis

Solution Approach

<table>
<thead>
<tr>
<th>If we...</th>
<th>Then we will...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add ability to track all specialty referrals (internal &amp; external)</td>
<td>Meet needs of patients, providers, clinic staff &amp; contracts</td>
</tr>
<tr>
<td>Draft Appointment Center standard work to copy referral # from Appointment Request List to Lifelink scheduling</td>
<td>Track referral status &amp; results through the referral process</td>
</tr>
<tr>
<td>Track critical referral appointment</td>
<td>Meet NCQA certification referral standards</td>
</tr>
<tr>
<td>Educate providers on all the capabilities of the Appointment Request List</td>
<td>Reduce the complexity of tracking referrals and improve communication</td>
</tr>
<tr>
<td>Develop standard referral terminology</td>
<td>Communicate more effectively</td>
</tr>
<tr>
<td>Create a Referral Champions at each CHS clinic</td>
<td>Proactively coordinate the care of specialty appointments to avoid wasted specialty appointments</td>
</tr>
</tbody>
</table>

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CHS Medical Home Care Team RIE

DATE: May 23-26, 2011

TEAM
- Patty Brewis – Process Owner
- Tina Quintana – Team Lead
- Brad Torok
- Della Harr
- Vale Escalera
- Camilla Robles
- Ray Estacio
- Lauren Gray
- Fred Kampe – Lean Facilitator

CONSULTANTS
- Paul Melnikovich
- Vickie Lesnansky
- Pete Gutierrez
- Angela Cuencas
- Richard Kornfeld

Solutions
- Visual Management
- Action Boxes
- Care Team Flyer
- Production Board (Continuity & No-Shows)

Standard Work
- Team Time
- Provider Coverage
- Guidelines
- HCP08 Chart
- Documentation
- HCP Superbill process
- Action Boxes
- Clerical Continuity & No-Show Tracking Log
## Visual Project Management

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Status</th>
<th>Milestones</th>
<th>Resources</th>
<th>Budget</th>
<th>Timeline</th>
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<tbody>
<tr>
<td>Project X</td>
<td>Green</td>
<td>Complete</td>
<td>Available</td>
<td>$500K</td>
<td>6 months</td>
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<tr>
<td>Project Y</td>
<td>Yellow</td>
<td>In Progress</td>
<td>Limited</td>
<td>$300K</td>
<td>4 months</td>
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## Visual Management Boards

![Visual Management Board Image]
Formal Gemba Walks

Toyota Kata – Mike Rother

SEEING LEAN, CONTINUOUS IMPROVEMENT AND INNOVATION IN A NEW LIGHT

The research that led to the book Toyota Kata looked into the intention behind Toyota’s practices and principles.

When you get to this level, the lessons become universal – applicable to any challenge.

They may even change how you view your job as a leader and manager.

© Mike Rother
Toyota Kata – Mike Rother

DEVELOPING SOLUTIONS
VERSUS
IMPLEMENTING SOLUTIONS

If we believe the way to the target condition is clear, then we are in implementation mode. An implementation mode doesn’t develop people’s capability to continuously improve, adapt and innovate.

We are here

plan to be here

Obstacles

Unclear Territory

We want to be here

We don’t know to advance what all the steps will be that will get us to the next desired condition. Like landing an airplane from 30,000 feet altitude.

There are only three things we can and need to know with certainty:
1. Where we are
2. Where we want to be
3. By what means we should maneuver the unclear territory between here and there.

© Mike Rother

Why Transform Primary Care?

• Continued rise in health care costs
• Current ‘system’ not working to bend the cost curve
  – Many non-value added activities (AKA waste)
    o Estimate $700 billion in waste in health care*
  – Need to improve patient safety and quality
  – Reduction and uncertainty in health care resources
  – Primary Care workforce shortages
  – Silos of care and communication
• Triple Aim
• Evidence that advanced primary care can bend the cost curve
• But how? PCMH?
High Cost/High Risk Patients

1% of US population

- Run daily
- 1+ hospitalization must have occurred since 11/16/2012
- OR 2+ hospitalizations, 1 of which was for serious mental illness, 1 of which was before 11/16 and 1 was after
- Patient is >= 19 yrs., unless on the CSHCN registry
- Visits can occur at both Denver Health & non-DH facilities
- OR diagnosis of serious mental illness (in/out patient) & 2 or more Inpatient Stays for any reason

Who are they?
- Hot spotters, chronically mentally ill

What is the optimal venue to manage them? Is it in primary care?

Medicare Costs & Chronic Conditions

Patients with 5 or more chronic conditions cost 17 times more than patients with no chronic conditions.

Care Management Models*

- Health Plan Model
- Primary Care Model
- aICU (ambulatory intensive care unit)
- Hospital Discharge Model
- Emergency Department Based Model
- Home-Based Model
- Housing First Model
- Community Based Model


Community Health Centers (CHC): Founding Principles

- Meet the needs of the deprived populations through new models of primary care
- Provide personal curative and preventive care as well as community targeted public health interventions
- Community participation
- Community control of the health services
- Use of epidemiologic methods to identify and prioritize interventions
- Expanded health center team beyond traditional clinical personnel
- Goal to reduce disparities in healthcare and health status

Practice Transformation at Denver Health

- Foundational concepts of Community Health Centers
- 1990’s Disease Based Collaboratives
- 2000’s: Outpatient Practice Redesign and the Chronic Care Model
- 2008: PCMH / Safety Net Medical Home Initiative
- 2012: Enhancing services for high risk high cost patients: Centers for Medicare and Medicaid Innovation (CMMI) Grant
  - Additional clinical and HIT (Health Informational Technology) resources to support enhanced primary care teams
  - Practice transformation focused on high-risk patients. (Where most potential savings exists)

2011 PCMH Content and Scoring

<table>
<thead>
<tr>
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<tr>
<td>A. Access During Office Hours**</td>
<td>4</td>
<td>A. Patient Information</td>
<td>4</td>
<td>A. Measure Performance</td>
<td>4</td>
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<tr>
<td>B. After-Hours Access</td>
<td>4</td>
<td>B. Clinical Data</td>
<td>4</td>
<td>B. Measure Patient/Family Experience</td>
<td>4</td>
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<tr>
<td>C. Electronic Access</td>
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<td>C. Comprehensive Health Assessment</td>
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<td>C. Implement Continuously Quality Improvement**</td>
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<tr>
<td>D. Continuity</td>
<td>2</td>
<td>D. Use Data for Population Management**</td>
<td>5</td>
<td>D. Demonstrate Continuous Quality Improvement</td>
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<td>E. Medical Home Responsibilities</td>
<td>2</td>
<td>E. Care Management**</td>
<td>4</td>
<td>E. Report Performance</td>
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<td>F. Culturally and Linguistically Appropriate Services</td>
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<td>F. Medication Management</td>
<td>3</td>
<td>F. Report Data Externally</td>
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<td>G. Practice Team</td>
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<td>G. Use Electronic Prescribing</td>
<td>3</td>
<td>G. Use of Certified EHR Technology</td>
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**Must Pass Elements

- 2011 PCMH Content and Scoring
- Standard 1: Enhance Access and Continuity
- A. Access During Office Hours**
  - Pts = 4
- B. After-Hours Access
- C. Electronic Access
  - Pts = 2
- D. Continuity
  - Pts = 2
- E. Medical Home Responsibilities
  - Pts = 2
- F. Culturally and Linguistically Appropriate Services
  - Pts = 2
- G. Practice Team
  - Pts = 4

- Standard 2: Identify and Manage Patient Populations
- A. Patient Information
  - Pts = 4
- B. Clinical Data
  - Pts = 4
- C. Comprehensive Health Assessment
  - Pts = 4
- D. Use Data for Population Management**
  - Pts = 5

- Standard 3: Plan and Manage Care
- A. Implement Evidence-Based Guidelines
  - Pts = 4
- B. Identify High-Risk Patients
  - Pts = 4
- C. Care Management**
  - Pts = 4
- D. Medication Management
  - Pts = 3
- E. Use Electronic Prescribing
  - Pts = 3

- Standard 4: Provide Self-Care Support and Community Resources
- A. Support Self-Care Process**
  - Pts = 6
- B. Provide Referrals to Community Resources
  - Pts = 3

- Standard 5: Track and Coordinate Care
- A. Test Tracking and Follow-Up
  - Pts = 6
- B. Referral Tracking and Follow-Up**
  - Pts = 3
- C. Coordinate with Facilities/Care Transitions
  - Pts = 3

- Standard 6: Measure and Improve Performance
- A. Measure Performance
  - Pts = 4
- B. Measure Patient/Family Experience
  - Pts = 4
- C. Implement Continuously Quality Improvement**
  - Pts = 4
- D. Demonstrate Continuous Quality Improvement
  - Pts = 3
- E. Report Performance
  - Pts = 3
- F. Report Data Externally
  - Pts = 2
- G. Use of Certified EHR Technology
  - Pts = 6

Note: **Must Pass Elements

- 2011 PCMH Content and Scoring
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  - Pts = 3
- E. Report Performance
  - Pts = 3
- F. Report Data Externally
  - Pts = 2
- G. Use of Certified EHR Technology
  - Pts = 6

Note: **Must Pass Elements
• Safety Net Medical Home Initiative
  • Four year initiative of the Commonwealth Fund
    – (2009 to 2013)
  • CCHN (Colorado Community Health Network)
    ○ Selected in 2008 to be one of 5 networks nationally
  • 15 FQHC’s in Colorado including 3 at Denver Health

Safety Net Medical Home Change Concepts*

• Engaged Leadership
• Quality Improvement Strategy
• Empanelment
• Continuous Team Based Healing Relationships
• Patient-Centered Interactions
• Organized, Evidence-Based Care
• Enhanced Access
• Care Coordination

• * http://www.safetynetmedicalhome.org/
SNMHI Change Concepts & Risk Status

Empanelment
• Use panel data and registries to proactively contact and track patients by disease status, risk status, self-management status, community and family need

Organized, Evidence-Based Care
• Identify high risk patients and ensure they are receiving appropriate care and case management services

Care Coordination
• Track and support patients when they obtain services outside the practice, including ED or hospital discharge follow-up

What is Care Coordination?

Reducing Care Fragmentation in Primary care:
• Link patients with community resources to facilitate referrals and respond to social service needs
• Integrate behavioral health and specialty care into care delivery through co-location or referral agreements
• Track and support patients when they obtain services outside the practice
• Follow-up with patients within a few days of an emergency room visit or hospital discharge
• Communicate test results and care plans to patients/families
• Provide care management services for high risk patients

http://www.safetynetmedicalhome.org/change-concepts/care-coordination
Practice Coaches

- Assist in development, support and follow-up of PCMH standard work
- Support project champions in the clinics
- Coordinate work with enhanced care teams
  - Ensure that practices for all target populations meet PCMH criteria for implementation and documentation
- Work with CMMI team to assure application of PCMH to high risk populations
PCMH & CMMI

- NCQA 2011 standards
  - Self-management support and care coordination standards more robust than previous version.
  - Transitions of care
  - Requirement to identify a high risk population within the practice
- 21st Century Care program at Denver Health
  - Analytical tools to identify high risk population
  - Resources for care management of this group
  - Follow PCMH standards

21st Century Care Goals

Over the three-year grant period, ensure:

- Better Access:
  - Increase access to care by 15,000 people
- Better Care & Health:
  - Improve overall population health for DH patients by 5%
  - Improve patient satisfaction with care delivered between visits by 5% without decreasing satisfaction with visit-based care
- Lower Cost:
  - Decrease total cost of care by 2.5% relative to trend
  - Reduce CMS spending by $12.8 million relative to trend
21st Century Care Goals

Denver Health 21st Century Care Driver Diagram

Aims
- Denver Health (DH) will develop a 21st century ambulatory care model by improving population health and patient experience of care while decreasing costs:
  - Improve overall population health for DH patients by 5% over the 3 year period.
  - Improve patient satisfaction with between visit care by 5% over the 3 year period without decreasing satisfaction with visit-based care.
  - Increase access to care for 10,000 patients over the 3 year period.

Primary Drivers

Secondary Drivers

Patient Counts

Baseline PBPYs

Project Services

Multidisciplinary High Risk Health Teams

PN, RN, PharmD, BHC, HIT

PN BHC HIT

HIT

Tier 4
1,283
Adult 62%, Peds 38%

Tier 3
3,435
Adult 75%, Peds 25%

Tier 2
43,225
Adult 82%, Peds 18%

Tier 1
79,946
Adult 26%, Peds 74%

$54,384

$27,270

$5,152

$742

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Tiered Service Delivery Model

<table>
<thead>
<tr>
<th>Tier</th>
<th>Patient Counts</th>
<th>Baseline PBPYs</th>
<th>Project Services</th>
</tr>
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<tbody>
<tr>
<td>4</td>
<td>1,283</td>
<td>$54,384</td>
<td>Multidisciplinary High Risk Health Teams</td>
</tr>
<tr>
<td>3</td>
<td>3,435</td>
<td>$27,270</td>
<td>PN, RN, PharmD, BHC, HIT</td>
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<td>2</td>
<td>43,225</td>
<td>$5,152</td>
<td>PN BHC HIT</td>
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<tr>
<td>1</td>
<td>79,946</td>
<td>$742</td>
<td>HIT</td>
</tr>
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</table>

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Key Features of CMMI: Redesigned Care for the 21st Century

- **Implements Multi-Payer Approach:** Level One Care for All
- **Builds On/Optimizes PCMH:** with emphasis on the strategic use of visit time, patient activation/self-care support, right-sized, team-based staffing that integrates practice-based with centralized strategies
- **Leverages Technology:** to implement low-touch activities to improve communication
- **Redesigns Care Model for High-Risk Populations:** comprehensive, staff-intensive approach that considers social, behavioral, physical needs across the care continuum (e.g. broader than just hospital discharge or PCMH)

Key Features of CMMI: Redesigned Care for the 21st Century

- **Incorporates Current Innovations:** e.g. text messaging, patient navigation/community health workers, co-located primary care/behavioral health services
- **Leverages Integrated System to Demonstrate New Innovations:** additional/better integration of substance abuse and behavioral health, specialty services
- **Builds Community Linkages/Capacity:** leverages Mental Health Center of Denver (MHCD), patient navigator infrastructure to connect patients to the broader Denver community
- **Leverages Lean for Implementation**
CMMI Clinical Workforce

$8.9 million in support for clinical staff at 8 distinct sites in different neighborhoods
• 11 primary care sites
Develop 3 high risk teams
• Children with Special Health Care Needs clinic
• Adult Intensive Outpatient Clinic
• Mental health high risk clinic (MHCD ACT team)
Achieve practice transformation: integrate new staff with existing staff to provide team-based care, especially to high-risk high-cost patients

Clinical Support Roles
• 25 patient navigators to support tier 2, 3 and 4 patients
• 3 pediatric nurse care coordinators to support tiers 2, 3 and 4 kids
• 3 clinical pharmacists to support tiers 2, 3 and 4 adult patients
• 5 behavioral health consultants (BHCs) to allow full behavioral health integrated care at all of our sites
• Staff for new high risk teams
Clinical Support Roles

Peds High Risk (CSHCN)  
- 0.5 LCSW  
- 0.5 Nutritionist  
- 0.2 Physical Therapist*  
- 1.0 Navigator  
- 0.25 Pediatrician*  
- 0.2 Child Psychologist*  
- 1.0 RN*  
- 0.2 Speech therapist*  
- 1.0 Medical Assistant*

Adult High Risk Clinic (IOC)  
- 1.0 charge RN  
- 1.0 Substance abuse counselor (CAC II)  
- 1.0 LCSW  
- 1.0 Navigator*  
- 0.5 clinical pharmacist  
- 0.1 clinical psychologist  
- 1.0 NP/PA*  
- 0.5 GIM MD*  
- 1.0 clerk*  
- 1.0 Medical assistant*

Why Case Conference?

Needed an intervention to help meet CMMI grant goals and objectives  
- Improve health of patient and reduce costs  
- Identify issues that wouldn’t present during clinic visits  
- Help reduce social barriers that are actionable  
- Provide multidisciplinary approach to patient-centered care  
- Increasing patient education  
- Reduce avoidable utilization by actionable patients  
- Improve communication through acute admission and outpatient work
High Risk High Cost Case Conferences

Lean Journey – Case Conferences Pilot

• Began as lean event planning for case conferences in June
• Process for multidisciplinary care teams to review the social, behavioral, and medical conditions of selected high-risk patients
• Develop care plans that will generate significant improvements in patient health, reduce utilization of services, and generate significant cost savings
• Targets patients in tiers 3 and 4 with a focus on high utilizers of the hospital and/or ED

Case Conference Process

• Included all members of the care team: BHCs, SWs, PNs, RNs, PharmDs, PCPs, HCPs
• PCP finalized list of selected patients to 5-10 “actionable” patients
• Clinic staff member contacts patient prior to conference to elicit patient goals and barriers
  o Become topics for the case conference
• Patient leaves with a care plan outlining clinic team recommendations and plans
### Lessons Learned

- Very time-intensive for patient identification and meeting for care team
- Pilots confirmed the importance of asking the patient about their non-medical issues
  - Vast majority of action items were non-medical
- Communication of the care plan is key to the design
  - Follow-up on care plan is challenging
- Patient navigators have a key role in task follow-up
- Frequent multidisciplinary team meetings unsustainable
High Risk High Cost Care Coordination

Lean Journey – Care Coordination

- Created modified process for care coordination
  - Patient Navigators lead coordination efforts with care team and patient
  - Narrowed list of patients to receive targeted care coordination
- Discontinue frequent large team meetings ("case conferences")
- Greater emphasis on small team huddles, brief consults and email
Lessons Learned

• Need to brief entire care team on the new standard work and why we’re investing in care coordination
• Care teams more willing to work on care coordination with a smaller, more manageable list of patients
• Still have varying degrees of comfort with patient navigator roles and responsibilities
• Need to set standards for when to “quit” conferencing each patient

Expected Outcomes of Care Coordination

• Patients will manage medications more appropriately
• Patients will have a better understanding of their health conditions
• Fewer visits to the ER for primary care-treatable conditions
• Fewer hospital admissions for poor control of chronic conditions
• More efficient use of PCP time --> increased access for additional patients
Patient Tiering

Goals of patient tiering are:
• Match care management resource to need/risk
• Improve quality of care at reduced costs
• Implement PCMH enhancements in a financially sustainable way

How?
• Predictive modeling: Clinical Risk Groups (CRGs)
• Diagnosis, procedure, pharmacy, utilization
• Clinical registry Information
• Future: demographic characteristics, health risk assessment information

Key Implementation Milestones
• 1/31/12 — Milliman Tiering (grant)
• 11/14/12 — DH Tiering Algorithm 1.0
• 5/1/13 — DH Tiering Algorithm 2.0
• Spring 2013: Tier assignments visible to clinics
• Summer 2013: Tiering on a monthly basis
• 4/1/14 (planned) – DH Tiering Algorithm 3.0

Tiering Methodology

CRG Status by Tier 21st Century Care

<table>
<thead>
<tr>
<th>CRG Status</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
<th>Tier 4</th>
<th>Total</th>
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<td>21,701</td>
<td>301</td>
<td>8</td>
<td>22,010</td>
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<tr>
<td>History of Significant Acute Disease</td>
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<td>52</td>
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<tr>
<td>Single Minor Chronic Disease</td>
<td>1,495</td>
<td>2,748</td>
<td>5</td>
<td>4,248</td>
<td></td>
</tr>
<tr>
<td>Minor Chronic Disease in Multiple Organ Systems</td>
<td>1,303</td>
<td>1,182</td>
<td>3</td>
<td>2,588</td>
<td></td>
</tr>
<tr>
<td>Single Dominant or Moderate Chronic Disease</td>
<td>272</td>
<td>16,420</td>
<td>577</td>
<td>65</td>
<td>11,334</td>
</tr>
<tr>
<td>Significant Chronic Disease in Multiple Organ Systems</td>
<td>11,633</td>
<td>3,717</td>
<td>629</td>
<td>15,979</td>
<td></td>
</tr>
<tr>
<td>Dominant Chronic Disease in 3 or more Organ Systems</td>
<td>57</td>
<td>1,795</td>
<td>1,053</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dominant, Neoplastic and Complicated Malignancies</td>
<td>422</td>
<td>91</td>
<td>913</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catastrophic Conditions</td>
<td>967</td>
<td>220</td>
<td>213</td>
<td>1,000</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>26,843</td>
<td>27,526</td>
<td>4,571</td>
<td>2,818</td>
<td>68,958</td>
</tr>
</tbody>
</table>

Report Name: Count by CRG Status.rpt
Patients in Tiers 3 and 4

**Adults Tier 3**
- Patients assigned to Tier 3 by base CRG
- Patients with 1+ inpatient stays in previous 6 months
- Patients with 2+ visits to the ED in the previous 6 months

**Adults Tier 4**
- Patients assigned to a Tier 4 by base CRG
- Patients with 3+ inpatient stays in previous 12 months
  - Includes ED observations and boarders
- Patients with 2+ inpatient stays and a diagnosis of a serious mental health condition
- “Frequent Flyers” that are assigned by CRG

Patients on Care Coordination List

- Adult High Risk patient – this is defined by having a CRG status of 6, 7 or 9, a CRG level of 4, 5 or 6 and 1+ Inpatient Stays or 2+ ED visits in the previous 6 months
- Remove any patient with 2+ Denver Cares (substance abuse) visits in the previous 6 months
Internal Evaluation Framework

Evaluation Framework

<table>
<thead>
<tr>
<th>Domain</th>
<th>Metrics/Analytical Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Reach</td>
</tr>
<tr>
<td></td>
<td>Workforce metrics by target population and by tier (e.g., navigation contacts, HIT reminders)</td>
</tr>
<tr>
<td>E</td>
<td>Effectiveness</td>
</tr>
<tr>
<td></td>
<td>Actuarial/financial, utilization, preventive service receipt, chronic care management, patient satisfaction. (Routine reporting &amp; follow-up analyses)</td>
</tr>
<tr>
<td>A</td>
<td>Adoption</td>
</tr>
<tr>
<td></td>
<td>Hiring and other workforce metrics by clinic (e.g., navigators hired/trained/placed, navigation contacts, HIT reminders)</td>
</tr>
<tr>
<td>I</td>
<td>Implementation</td>
</tr>
<tr>
<td></td>
<td>Patient satisfaction and provider interviews</td>
</tr>
<tr>
<td>M</td>
<td>Maintenance</td>
</tr>
<tr>
<td></td>
<td>Trend analysis of routinely reported financial, clinical, and workforce metrics.</td>
</tr>
</tbody>
</table>

Lessons Learned and Summary

- PCMH: Existing practice
- MHCD: Unengaged patient
- IOC: High Risk Care Coordination
Contact Information

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• The contents are solely the responsibility of the authors and have not been approved by the Department of Health and Human Services, Centers for Medicare & Medicaid Services

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