ACO Accelerated Development Learning Session

Baltimore, MD
November 17–18, 2011

Module 2B: Care Delivery—Coordinating Care and Managing High-Risk, High-Cost Beneficiaries

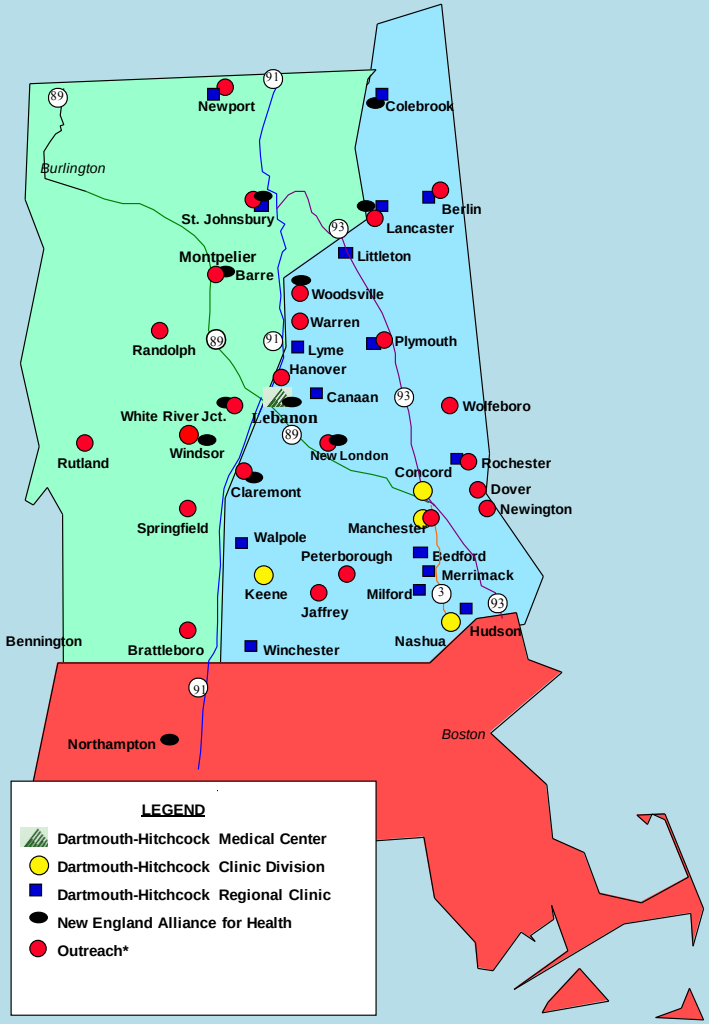
November 17, 2011
3:45–5:45 p.m.

Barbara Walters, DO, MBA
Dartmouth-Hitchcock
Senior Medical Director

Agenda

- Introductions
- Defining and Selecting High-Risk Patients
- Models of Care Coordination
- Measuring Effectiveness
- Resources
- Group Discussion

Dartmouth-Hitchcock Health System Map (2011)



- Dartmouth-Hitchcock Medical Center–Lebanon (396 beds)
- Dartmouth-Hitchcock Clinic Community Group Practices
  - Concord
  - Keene
  - Manchester
  - Nashua
- Regional clinics (15)
- Outreach (24)
- New England Alliance for Health (NEAH–12)
- The Dartmouth Institute

Dartmouth-Hitchcock

Operations

- 1,700,000 outpatient visits per year
- 23,000 inpatients
- 1,000+ physicians

Compensation Model

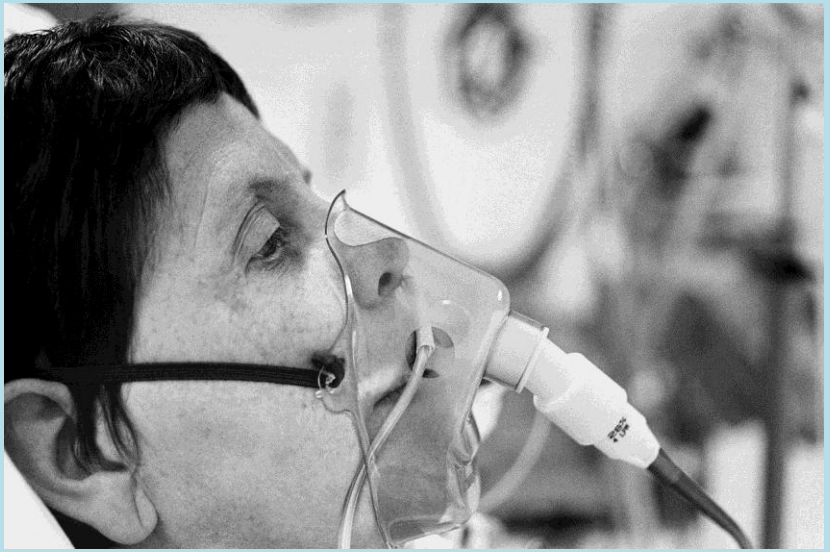
- 8,700 employees
- 900+ medical students, residents, and fellows
- Reimbursement environment—All fee-for-service (FFS)
- Electronic medical records (EMRs) and data warehouse
- Patient portal and e-visit reimbursement

Dartmouth-Hitchcock's "ACO" Experience

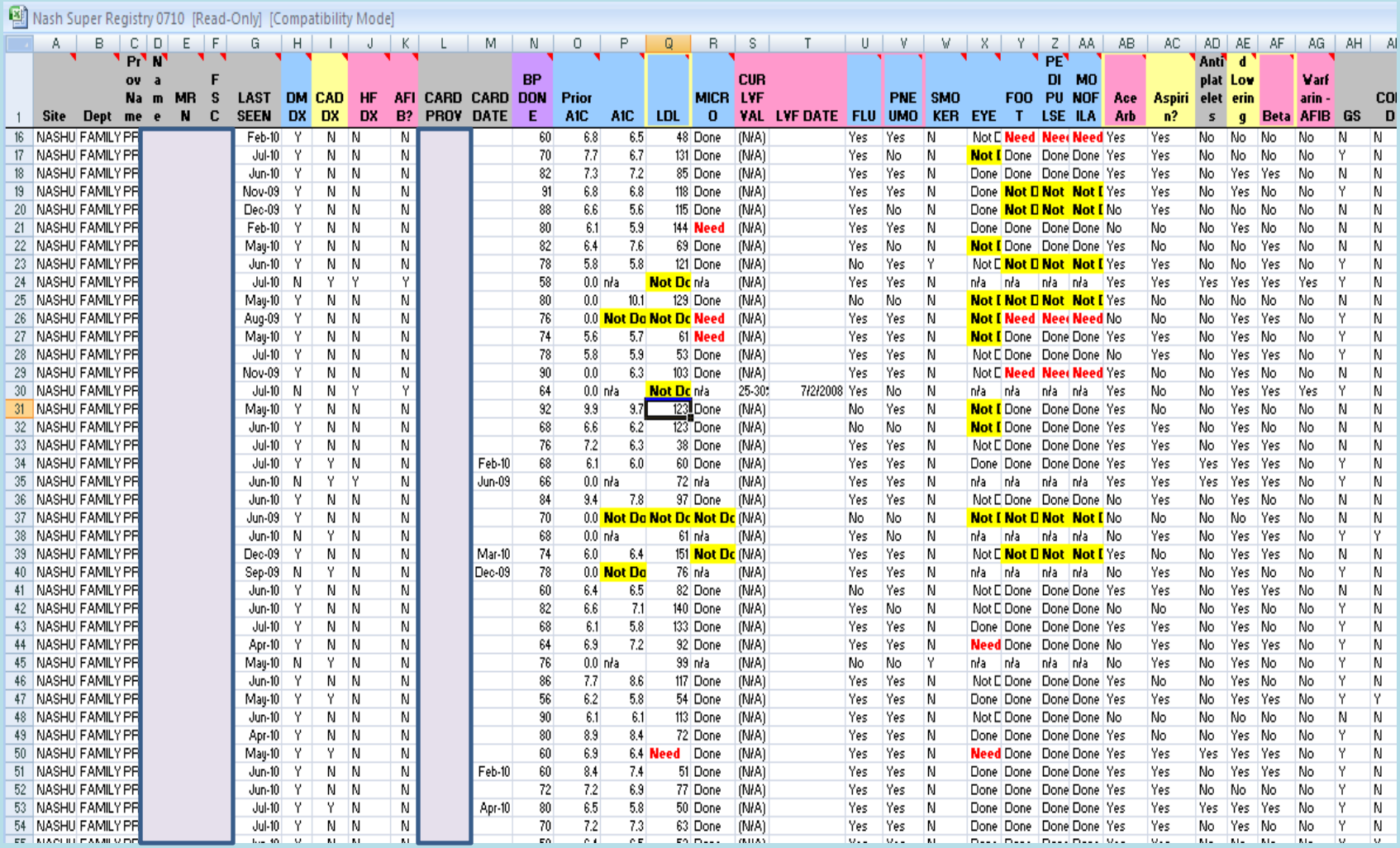
- CMS Physician Group Practice Demonstration Project
- CMS Transition Demo
- Cigna—Primary Care Attribution Model ACO
- Anthem/Wellpoint & Harvard Pilgrim—Medical Cost Target Model in preparation for an ACO
- Citizens Health Initiative in NH—All Payer Medical Home Pilot and ACO pilot
- Pioneer ACO Invitee
- Bundled Payment LOI

The Who: Defining and Selecting High-Risk Patients

- Who are our patients
- Which patients are high risk
- For which patients can we impact their risk
- Three-pronged approach
  - Design our own algorithm
  - Software predictive model
  - Just ask



Chronic Disease Super Registry (for Population and Patient Management)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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
1	Site	Dept	Prov Name	Name	MRN	FSC	LAST SEEN	DM DX	CAD DX	HF DX	AFIB?	CARD PROV	CARD DATE	BP DONE	Prior A1C	A1C	LDL	MICRO	CUR LVF VAL	LVF DATE	FLU	PNEUMO	SMOKER	EYE	FOOT	PE DIL PUSE	MONOFILA	Ace Arb	Aspirin?	Antiplatelets	dLowering	Beta	Warfarin - AFIB	GS	COD
16	NASHU	FAMILY PR					Feb-10	Y	N	N	N			60	6.8	6.5	48	Done	(N/A)		Yes	Yes	N	Not D	Need	Need	Need	Yes	Yes	No	No	No	No	N	N
17	NASHU	FAMILY PR					Jul-10	Y	N	N	N			70	7.7	6.7	131	Done	(N/A)		Yes	No	N	Not D	Done	Done	Done	Yes	Yes	No	No	No	No	Y	N
18	NASHU	FAMILY PR					Jun-10	Y	N	N	N			82	7.3	7.2	85	Done	(N/A)		Yes	Yes	N	Done	Done	Done	Done	Yes	Yes	No	Yes	Yes	No	N	N
19	NASHU	FAMILY PR					Nov-09	Y	N	N	N			91	6.8	6.8	118	Done	(N/A)		Yes	Yes	N	Done	Not D	Not	Not D	Yes	Yes	No	Yes	No	No	Y	N
20	NASHU	FAMILY PR					Dec-09	Y	N	N	N			88	6.6	5.6	115	Done	(N/A)		Yes	No	N	Done	Not D	Not	Not D	No	Yes	No	No	No	No	N	N
21	NASHU	FAMILY PR					Feb-10	Y	N	N	N			80	6.1	5.9	144	Need	(N/A)		Yes	Yes	N	Done	Done	Done	Done	No	No	No	Yes	No	No	N	N
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23	NASHU	FAMILY PR					Jun-10	Y	N	N	N			78	5.8	5.8	121	Done	(N/A)		No	Yes	Y	Not D	Not D	Not	Not D	Yes	Yes	No	No	Yes	No	Y	N
24	NASHU	FAMILY PR					Jul-10	N	Y	Y	Y			58	0.0	n/a	Not Do	n/a	(N/A)		Yes	Yes	N	n/a	n/a	n/a	n/a	Yes	Yes	Yes	Yes	Yes	Yes	Y	N
25	NASHU	FAMILY PR					May-10	Y	N	N	N			80	0.0	10.1	129	Done	(N/A)		No	No	N	Not D	Not D	Not	Not D	Yes	No	No	No	No	No	N	N
26	NASHU	FAMILY PR					Aug-09	Y	N	N	N			76	0.0	Not Do	Not Do	Need	(N/A)		Yes	Yes	N	Not D	Need	Need	Need	No	No	No	Yes	Yes	No	Y	N
27	NASHU	FAMILY PR					May-10	Y	N	N	N			74	5.6	5.7	61	Need	(N/A)		Yes	Yes	N	Not D	Done	Done	Done	Yes	Yes	No	Yes	No	No	Y	N
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29	NASHU	FAMILY PR					Nov-09	Y	N	N	N			90	0.0	6.3	103	Done	(N/A)		Yes	Yes	N	Not D	Need	Need	Need	Yes	No	No	Yes	No	No	N	N
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33	NASHU	FAMILY PR					Jul-10	Y	N	N	N			76	7.2	6.3	38	Done	(N/A)		Yes	Yes	N	Not D	Done	Done	Done	Yes	Yes	No	Yes	Yes	No	N	N
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37	NASHU	FAMILY PR					Jun-09	Y	N	N	N			70	0.0	Not Do	Not Do	Not Do	(N/A)		No	No	N	Not D	Not D	Not	Not D	No	No	No	No	Yes	No	N	N
38	NASHU	FAMILY PR					Jun-10	N	Y	N	N			68	0.0	n/a	61	n/a	(N/A)		Yes	No	N	n/a	n/a	n/a	n/a	No	Yes	No	Yes	Yes	No	Y	Y
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40	NASHU	FAMILY PR					Sep-09	N	Y	N	N		Dec-09	78	0.0	Not Do	76	n/a	(N/A)		Yes	Yes	N	n/a	n/a	n/a	n/a	No	Yes	No	Yes	No	No	Y	N
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46	NASHU	FAMILY PR					Jun-10	Y	N	N	N			86	7.7	8.6	117	Done	(N/A)		Yes	Yes	N	Not D	Done	Done	Done	Yes	No	No	Yes	No	No	Y	N
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49	NASHU	FAMILY PR					Apr-10	Y	N	N	N			80	8.9	8.4	72	Done	(N/A)		Yes	Yes	N	Done	Done	Done	Done	Yes	No	No	Yes	No	No	Y	N
50	NASHU	FAMILY PR					May-10	Y	Y	N	N			60	6.9	6.4	Need	Done	(N/A)		Yes	Yes	N	Need	Done	Done	Done	Yes	Yes	Yes	Yes	Yes	No	Y	N
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52	NASHU	FAMILY PR					Jun-10	Y	N	N	N			72	7.2	6.9	77	Done	(N/A)		Yes	Yes	N	Done	Done	Done	Done	Yes	Yes	No	No	No	No	Y	N
53	NASHU	FAMILY PR					Jul-10	Y	Y	N	N		Apr-10	80	6.5	5.8	50	Done	(N/A)		Yes	Yes	N	Done	Done	Done	Done	Yes	Yes	Yes	Yes	Yes	No	Y	N
54	NASHU	FAMILY PR					Jul-10	Y	N	N	N			70	7.2	7.3	63	Done	(N/A)		Yes	Yes	N	Done	Done	Done	Done	Yes	Yes	No	Yes	No	No	Y	N

The How: Clinical Approach and Interventions

- Engage the physicians and first do no harm (to the docs)!
- Clinical care delivery
  - Physician champions
  - Best practice and care processes—the team
  - Practice redesign—the medical home
- Transform the role of the RN—coaches and coordinators
- Exquisite attention to diagnosis and problem lists
- Monitor progress and provide feedback

Transforming the Role of the RN—Key Competencies

- Acts as patient advocate and educator
- Assesses patient's readiness for change
- Acts as clinical liaison within the primary care team and to anchor specialists
- Manages transitions in care
- Develops plan of care and keeps plan current
- Initiates and acts per protocol for disease management as appropriate
- Institutes previsit planning and gaps in care evaluation and outreach
- Initiates shared decisionmaking process per condition
- Functions as part of care delivery team

Care Coordination Implementation

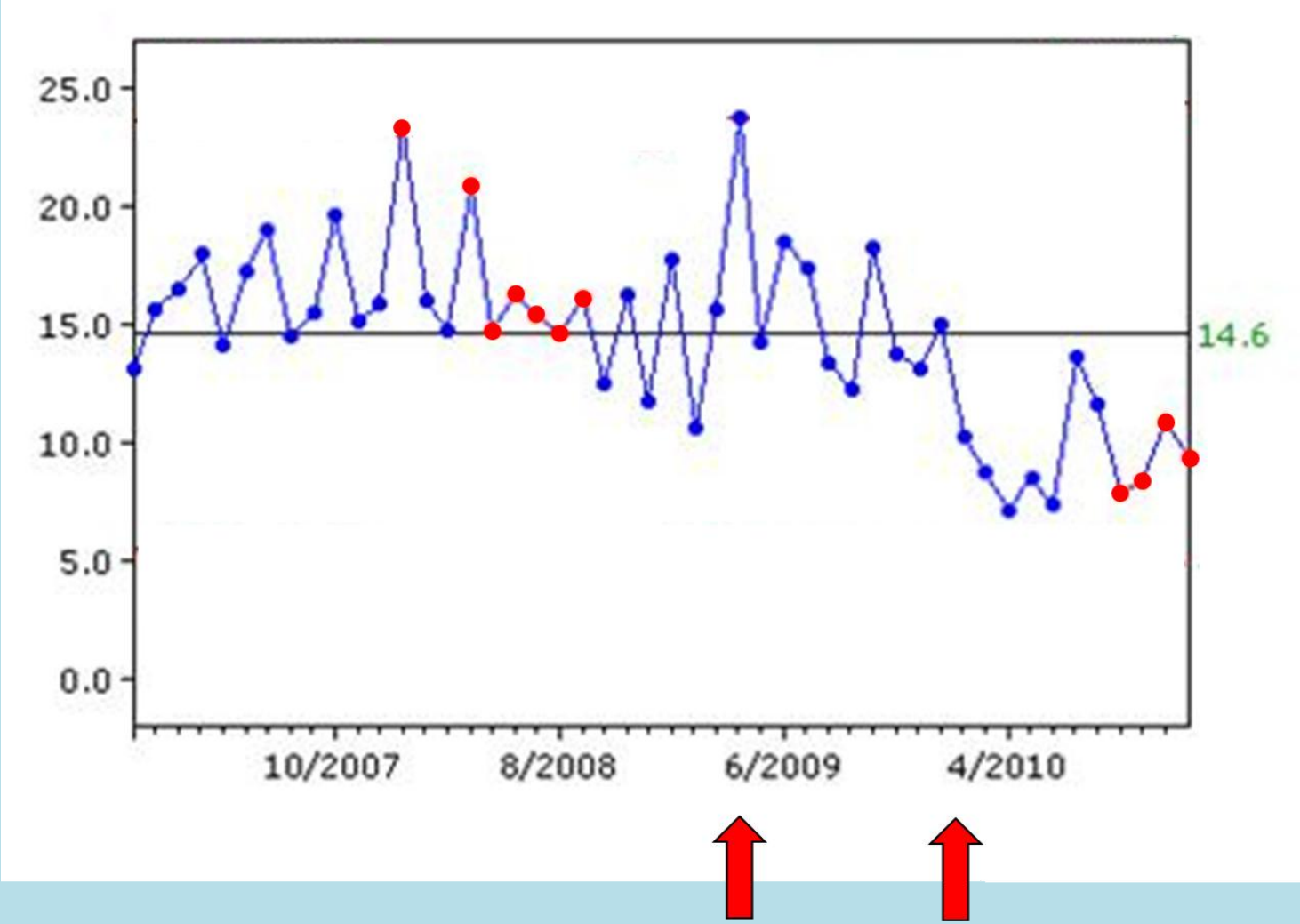
- Job description and skill reinvigoration or building
- Managing our most complicated patients: “Just enough”
- Teaching the docs who to refer
- Locate within our primary care departments
- Ratios?
  - 1:5,000 commercial and 1:500 Medicare
  - How part time can a nurse be and still be part of a team?
- Develop a prioritization plan:
  - Disease focused to start: Diabetes … then morphed into patient focused
  - Worked on hospital discharges
- Hardest work—When to “let go”

How Will I Know If Care Coordination Is Successful?

- For individual patients
  - Clinical outcomes improve
  - Gaps in care close
  - Risk score decreases
- Impact on the total initiative
  - What are the major contributors to the total cost of care and quality targets
- Effectiveness of the care coordinators

Acute Care Age >64% Readmit Within 30 Days

Cheshire Medical Center: 1/2007–12/2010 Monthly



Dartmouth-Hitchcock
Care Coordination Activity Tracking Log

Dartmouth-Hitchcock

Care Coordination Activity Tracking Log

The purpose of the activity tracking is to capture care coordination activities provided by CM/CC/SW related to: volume of patients/families touched, level of service provided, and outcome.

COLUMN HEADERS and DEFINITIONS

DEMOGRAPHICS

Date of Touch = date of activity

Patient Last Name

Patient First Name

DOB = Date of Birth

Primary Care Provider = Name

Specialty Care Provider = Name

Insurance Plan

1 DH Anthem	6 Tufts
2 Medicare	7 Medicaid
3 CIGNA	8 None
4 Anthem	9 Other
5 Harvard Pilgrim	

DRAFT

Pertinent Diagnosis/Diagnoses = those that have relevance to work with patient/family

How we became aware of the patient?

1 Provider Care Team Member	5 Insurance Company Data Tool (CIGNA PreVise, DHVise,
2 Non Provider Care Team Member	6 External Agency or Vendor
3 Patient/Family	7 Other
4 DH Electronic Health Record Registry/Co-Hort Report	

Why CC/CM needed? A short description of why requester believes CC/CM is needed

ENGAGEMENT and PARTICIPATION

Patient in agreement to work with CC/CM/SW = yes or no

Care Coordination Start Date

Care Coordination Graduation Date

Activity

Post Hospital Follow-Up= an X in the box will be just fine

Post ED/UC Follow-Up= an X in the box will be just fine

Assessment= an X in the box will be just fine

Care Plan Intiated or Updated = I or U

Emergency Action Plan Initiated or Updated = I or U

Handoff to other Service:

Dartmouth-Hitchcock
Care Coordination Activity Tracking Log

Dartmouth-Hitchcock
Care Coordination Activity Tracking Log

1 Home Health	4 Community Agency
2 Hospice	5 Vendor
3 Financial Aid Office	6 Specialist or PCP
In Office Visit = an X in the box will be just fine	
Other = list what you did	
OUTCOME - CC/CM/SW Report	
Engagement of patient/family = an X in the box will be just fine	
Averted ED/UC visit = an X in the box will be just fine	
Averted Admission/Readmission = an X in the box will be just fine	
OUTCOME - Patient/Family Self Report	
Improved Quality of Life = an X in the box will be just fine	
Increased Ability to Self Manage Care = an X in the box will be just fine	
Increased Understanding of Condition = an X in the box will be just fine	
Got Help needed = an X in the box will be just fine	
No Change from Baseline = an X in the box will be just fine	
CC/CM/SW self report of time spent	
With Patient = # minutes in 15 minute increments	
Outside of Patient = # minutes in 15 minute increments	

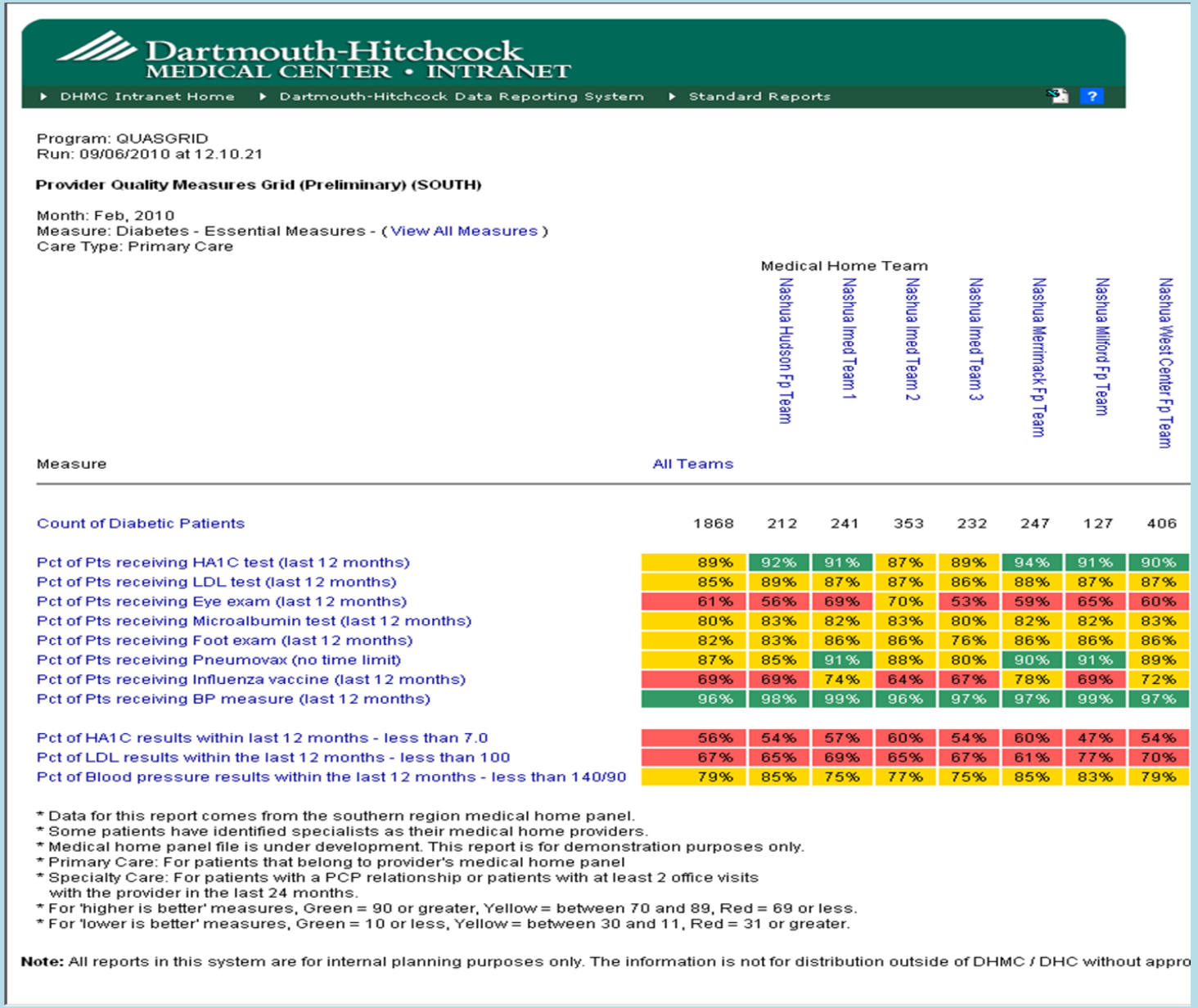
DRAFT

NOTES

Each CC/CM/SW will have their own workbook. A worksheet is set-up for each month of the year. Submission of workbook vs current month worksheet tbd.

Use a separate line for each episode of touch - call, outside of call, etc. Need to figure out how to bundle activities into an episode of touch

Exception Cases - how to note when don't fit the boxes of the tracking sheet - What are your thoughts?



Dartmouth-Hitchcock
MEDICAL CENTER • INTRANET

DHMC Intranet Home ▸ Dartmouth-Hitchcock Data Reporting System ▸ Standard Reports

Program: QUASGRID
Run: 09/06/2010 at 12.10.21

Provider Quality Measures Grid (Preliminary) (SOUTH)

Month: Feb, 2010
Measure: Diabetes - Essential Measures - (View All Measures)
Care Type: Primary Care

Measure	All Teams	Medical Home Team: Nashua Hudson Fp Team	Nashua Imed Team 1	Nashua Imed Team 2	Nashua Imed Team 3	Nashua Merrimack Fp Team	Nashua Milford Fp Team	Nashua West Center Fp Team
Count of Diabetic Patients	1868	212	241	353	232	247	127	406
Pct of Pts receiving HA1C test (last 12 months)	89%	92%	91%	87%	89%	94%	91%	90%
Pct of Pts receiving LDL test (last 12 months)	85%	89%	87%	87%	86%	88%	87%	87%
Pct of Pts receiving Eye exam (last 12 months)	61%	56%	69%	70%	53%	59%	65%	60%
Pct of Pts receiving Microalbumin test (last 12 months)	80%	83%	82%	83%	80%	82%	82%	83%
Pct of Pts receiving Foot exam (last 12 months)	82%	83%	86%	86%	76%	86%	86%	86%
Pct of Pts receiving Pneumovax (no time limit)	87%	85%	91%	88%	80%	90%	91%	89%
Pct of Pts receiving Influenza vaccine (last 12 months)	69%	69%	74%	64%	67%	78%	69%	72%
Pct of Pts receiving BP measure (last 12 months)	96%	98%	99%	96%	97%	97%	99%	97%
Pct of HA1C results within last 12 months - less than 7.0	56%	54%	57%	60%	54%	60%	47%	54%
Pct of LDL results within the last 12 months - less than 100	67%	65%	69%	65%	67%	61%	77%	70%
Pct of Blood pressure results within the last 12 months - less than 140/90	79%	85%	75%	77%	75%	85%	83%	79%

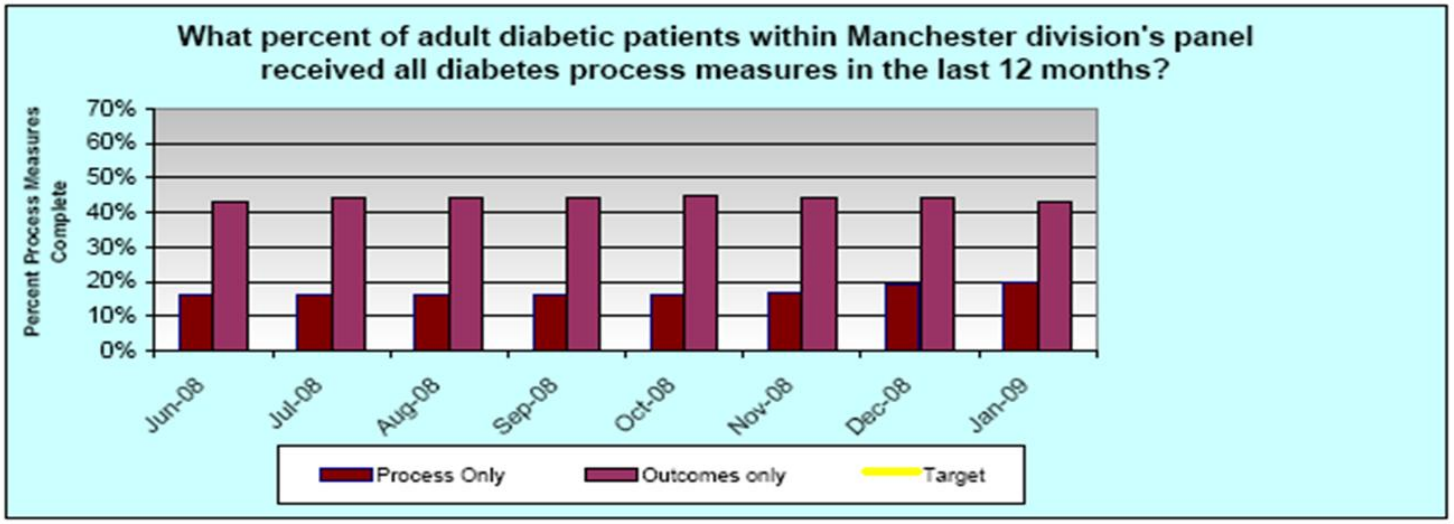
* Data for this report comes from the southern region medical home panel.
* Some patients have identified specialists as their medical home providers.
* Medical home panel file is under development. This report is for demonstration purposes only.
* Primary Care: For patients that belong to provider's medical home panel
* Specialty Care: For patients with a PCP relationship or patients with at least 2 office visits with the provider in the last 24 months.
* For 'higher is better' measures, Green = 90 or greater, Yellow = between 70 and 89, Red = 69 or less.
* For 'lower is better' measures, Green = 10 or less, Yellow = between 30 and 11, Red = 31 or greater.

Note: All reports in this system are for internal planning purposes only. The information is not for distribution outside of DHMC / DHC without appro

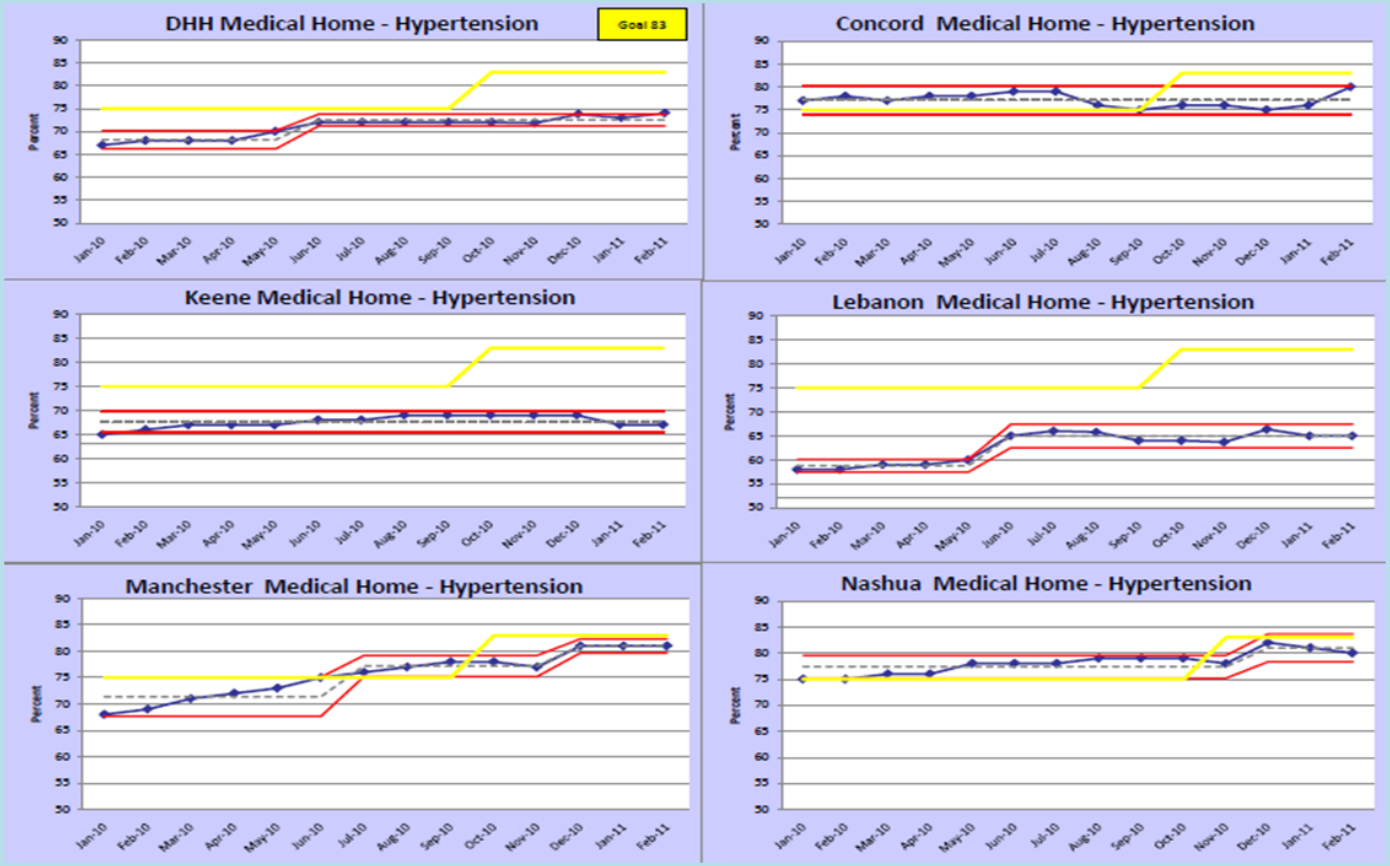
Quality Pillar – Composite Scores

What percent of adult diabetic patients within my panel received all DM measures in the last 12 months?

Division	PT COUNT	Composite w/o Eye & Foot %	Composite - Total %	Composite % - Process only	Composite % - Outcomes only
MANCHESTER	*3169*	*38%*	*12%*	*20%*	*43%*
Manch/Bedford FP	*1433*	*38%*	*11%*	*21%*	*40%*
Manch/Bedford IM	*1673*	*39%*	*13%*	*20%*	*46%*
Bedford FP	*626*	*38%*	*11%*	*19%*	*43%*
Bedford IM	*180*	*22%*	*6%*	*11%*	*33%*
Manchester FP	807	37%	12%	23%	38%
Manchester IM	1493	41%	13%	21%	48%
Manch IM/Pedi	63	29%	3%	11%	25%



What Percent of My Patients With a Diagnosis of HTN Have Both Systolic and Diastolic BP Values Less Than 140/90?



- As of Dec 10, the Manchester, Nashua, and Lebanon patient population in this report follows the medical home definition: patient is in a Medical Home if he or she had at least one Office Visit or Preventive Care Visit (based on EM cpt codes) within the preceding 3 years in DH Primary Care. The Medical Home Provider is the patient's RCP (regular care provider) if one has been selected, or the patient's PCP if no RCP has been chosen.

Patients seen in last 3 years.
Each month reflects most recent blood pressure taken in the 12 months.

What Resources Do You Need to Make Your Care Coordination Efforts Successful?

- Relationships
  - Hospitals
  - VNA, home-health, and hospice
  - SNF
  - Other providers
- Capital
- Staff
  - Training
  - Communication
- Informatics
  - EHRs
  - HIE
  - Analytics

Discussion Question 1: Identification of High-Risk Patients

- How will I identify my high-risk patients?
- How will I stratify and prioritize these patients to provide resources where they will have the most impact?

Discussion Question 2: Identification of Care Coordinators

- Who will be my care coordinators?
- Where will they be located and included as part of the care teams?
- Will I communicate this to our clinicians and patients?

Discussion Question 3:
Data to Support Care Coordination

- What data and reporting do I have currently available to support this effort, modify, or develop?
- Do I have an EHR: Do I need an EHR? Is there a care plan template with best practice alerts?
- Do I have a portal?

Discussion Question 4: Resources Needed

- Develop a resource needs list
  - Clinical staffing
  - Data, analysis, and reporting
  - Education, outreach, and communication
  - Initial/startup investment
  - Ongoing/operating investment
- Anticipated impact of care coordination
  - On quality of care (specific measures/indicators)
  - On total cost of care for high-risk patients
  - On total cost of care spread across all ACO patients

Project Timeline

Task	Timing	Reference
Project kickoff [project charter completion]	Week 1	• Meeting agenda link • CGP HTN Control Measures
Document current process	Weeks 2–3	Meeting agenda link
Root cause	Week 4	Meeting agenda link
Identify improvements	Week 5	Meeting agenda link
Implement improvements	Weeks 6–9	Meeting agenda link
Communicate progress	• Monthly for general status • As needed for major changes	• Post metrics on display board in department • E-mail communication announcing new changes • Team meeting reports

Questions?

Module 2B: Care Delivery—Coordinating Care and Managing High-Risk, High-Cost Beneficiaries

Barbara Walters, DO, MBA
Dartmouth-Hitchcock
Senior Medical Director