Minute
Improving & Bridging Systems Subcommittee
Department of Health Care Policy and Financing

CHORIO Office
4500 Cherry Creek South Drive, Suite 820,
Owl Creek Conference Room
Denver, CO

February 2, 2017, 1:00-2:30PM

Participant Dialing Instruction:
1. Dial: 1-855-851-0419
2. Participant Code: 250-540-6692#

Purpose or Goals:

➢ Make benefit design recommendations to the ACC PIAC to enhance care across systems
➢ Discuss and recommend ways to bridge systems in order to better integrate care and resources
➢ Identify barriers to access and communication across systems of care and community supports and recommend improvements

Reason for I&BS Establishment:

➢ Address issues unique to frequent users of the health care system

1. Introductions

As a result of weather condition, the meeting was offered through a conference call. Morgan opened the meeting at 1:00pm.

In person attendees

Morgan Honea (CORIHO) and Louisa Wren (Rocky Mountain Health Plans).
Phone Attendees

Carol Plock (Larimer County Health District), Mark Ferretti (Member Advocate), Amy Harder (RCCO 7), Carol Meredith (The Arch Arapahoe & Douglas Counties), Jane (Beacon Health Option), Sophie Thomas (HCPF), Terri Hurst (Colorado Criminal Justice Reform Coalition), Gary Montrose (The Independence Center), Alyssa Rose (Beacon Health Option), Rahem Mulatu (HCPF).

2. Announcements

Morgan Honea:

There are three vacancies for voting members, two physical health care providers and one Behavioral Health provider. Please nominate or let us know if you know anyone who is interested becoming a voting member, and email your recommendations to Carol, Morgan, or Rahem.

HCPF team will present the strategic plan for criminal justice population at the March PIAC meeting. Those who usually do not attend the meeting are encouraged to attend the presentation. Sophie will confirm the date and Rahem will email out the confirmation to I&BS members.

3. Committee Charter

- 6 Focus Areas + 3 delegated topics (LTSS/ Population Health/Criminal Justice) of high utilizers
- I&BS goal graphic description
  Focus what we have been charged to do, on the focus areas and delegated topics – specific to high utilizers
  The purpose of this group is to address high utilizers as charged by HCPF

Carol Plock:

Clarified about the charter, per the graphic focus area description, the committee has been charged to identify the High Utilizers (HU) and High Risk (HR) population groups. It is important to figure out a common way, and then what to do with the common findings, how to communicate with primary care providers and how would care coordination look like for effective best practices that works for all. Per the graphic outlines, there should be 3 focus area + 3 delegated topics.

The overall objective and goal of this committee is to identify frequent high utilizers, and make a difference while lowering cost.
4. **Area of Focus (Review & Discussion)**

Carol Plock & Morgan Honea

Carol Plock:

Referred the document “Summary of Hi Utilizer data request so far Oct 24 2016” that was emailed out from the previous I&BS subcommittee discussion. The discussion from last meeting entailed identifying HUs, how the processes can be used by providers, how HCPF can be involved, and what the deliverables will look like.

What is the purpose of the committee? What criteria to use to identify HU population groups? What to do with the information? How to be effective? We need to identify the HUs and go deeper such as what common factors are we looking: health conditions, geographical locations, age, and more - example, Diabetes, Substance Use Disorder (SUD), COPD. Across the board what are we doing? Do we need to design a new benefit, policy change, program change in RAE level, Care Coordination level, Provider level? What recommendation are we looking?

Previously, research has been done to find out whether the ‘payment reform model’ has been effective at reducing cost, but the research indicated that the model had few success and there no enormous change in reducing cost. Not a lot of different has been seen in quality of care. The quality measure is ‘iffy’. We have been way too spread thin how we approached things; instead, we need to find a ‘thing’ that we can make a difference, focus on that, that is where we see results.

The Key Initial Area of Focus A: Ability to identify high utilizers and those at high risk We want to identify and find common characteristics – what are the initial criteria to identify HU population groups? Data, Cost of care, Utilization patter? Take out people with terminal condition from the analysis.

➢ Please review the attached document in preparation to address these questions

Carol Plock: we need to find common conditions to start identifying HU. HCPF can be asked for Truven to assist us to run the current enrolls with the criteria that are considered by the committee.

Moran Honea: to look the cohort data and to identify the driver for HU. Do we have some potential criteria for HU?
Sophie: To work with Truven will be a 2-3 months out since they do not have the whole data, but Hana can be asked if Truven has the capacity to process the identified criteria for HU. Truven at this time is importing 6 years of data and it will take months to complete and they will take some time before they come to full operation.

Gary Montrose: does the criteria will address our objective? There is a gap/hole in this criteria, which reflects the traditional way of looking at things from HCPF’s perspective – a medical home model. We should target high cost HUs. Populations who receive long term care are costing the health care system (immensely). 18% of Medicaid population are disabled and senior, they consume 50% of the cost of the Medicaid budget. Acute care is not costing as much as LTSS. Identify the LTSS waiver program and catch those population (important), there is a poor alignment with acute care as costing the same as long term care population group. These criteria that is discussed does not reflect the LTSS population.

Morgan Honea: Define population by HU patter

Carol Ploc: LTSS use a great deal of the resources, the criteria will capture them; however, there are people who do not qualify for LTSS but still cost us HUs

Gary Montrose: Let’s start with this concept, start with medical intervention, social support, social determinant of health. Poor access to clinical care/acute care – LTSS population. There needs to be two buckets for the criteria.

Carol Ploc: Look for common condition for everyone without excluding any population group, then find the common solution. We do not know the right intervention, if it is care coordination, medication management, transportation, social services, or other. We do not know it (yet), unless we know the specific health condition that is identified by the LTSS group.

Morgan Honea: identifying criteria is a cross multiple factor and will capture the cohort, then work through them. What are the patters of HU for providers that need to be addressed?

Louisa Wren: For identifying HU, cost of care can be obtained from claim data, Truven has access. Does the data capture the population Gary addresses? Need more than acute care intervention for HUs. Can criminal justice populations be identified by cost? How they utilize services?

Carol Ploc: Evidence based programs have to be used for intervention, but nothing has been identified. Common condition can be identified.
Morgan Honea: Identify HU population by applying cost of care logic will help develop sub population group – ex. create eligibility category, special population group, TANF, Pregnant Mother, Criminal Justice Population, LTSS – Data will be good for program identification.

Carol Plock: What are the commonality across the different population group? What are the effective ways to approach intervention? What is costing us right now? Objectively, what can we do to make a difference. LTSS was not included in the current contract but it was a given to address this population group, so the criminal justice population are a given too.

Louisa Wren: The department will hold the RAE responsible for the entire population. Identify the population with a high dollar amount of utilization. Are the RAE working with providers (LTSS, social services, ...). Patient centered care approach will address the person with a high cost of care who is in the LTSS program and population released from the correction facility. They will get the services they need accordingly. After addressing cost, what is the next action that needs to be taken? What is the plan to prevent from crisis to occur that will affect their health?

Gary Montrose: Cost of care does not tell me anything, if it is a terminal event that occurred right before death or multiple events. What populations are we starting with, then we see what cost and gaps of care exists?

Carol Plock: Starting only from the LTSS population is creating an exclusion, what happen to the other population? Ex. people with heart failure who needs significant interventions. I am concerned if we look the small group – we need to look across the 1.3 million people and not be exclusive. We need to see this from a high level.

Gary Montrose: I want to do both populations without creating exclusion from a broad perspective. It is logical to work with special population, they are costing three times, we are defaulting to acute care metrics. We have to move away from that approach. Which criteria should we start first? Cost of care or certain population group – or both?

Mark Ferretti: First identify the large group – HUs, then make a sub group – what is underneath the sub group - LTSS, Criminal Justice Population, Behavioral Health

Morgan Honea: Find the criteria then move to #2, find the correlation, broad care coordination for the whole population is not effective.

Louisa Wren: Is there a potential to serve this population? Some services that are provided are not billable, but services being provided – so how does this service show under the cost claim? Are all costs show up in the claim data base?
Gary Montrose: Yes, the disability data, look into that.

Sophie: County data shows only services paid through Medicaid. This can be a question to bring to Truven, how to dice the data.

Gary Montrose: Claim analysis from HCPF does show this services and cost, for ex. CF, MS, high cost clinical. Code exists in HCPF data that shows who consumes high cost services.

Morgan Honea: Total cost of care – LTSS is Medicaid services

Carol Plock: Let’s focus where we can make a difference. Find the common conditions and cost effective interventions, no need to be exclusive.

Morgan Honea: Let’s agree to set criteria for identifying HUs - to take to PIAC meeting. Do not use the same methodology to make criteria for HU.

Carol Plock: Commonality for effective prevention – what can we do to change state wide, change from the current practice?

Morgan Honea: Is the list of process accepted?

Carol Plock: Low utilizers – High risk, how do we go about it, how do we know if it works, how do we know if it is worth to identify foster care children? Identifying social determinants will be easy with claim history. What data source to utilize to identify housing, poverty status.

Louisa Wren: Some people who are low risk – high utilizer can stay on the list for 3 months and be ok, and later they may have crises. How do you identify this people without claim? These low risk – high utilizers are known in the community. How do we identify and capture them to be in the radar? Is there any evidence based approach?

Morgan Honea: Develop a process to identify the HU populations in various spectrum - what are the data element behind it in regards to low risk – high utilizers if they are not in the system.

Carol Meredith: we had done analysis of cost for adults under the long term care waiver – and we found the adults in residential waiver have lower cost to the Medicaid state plan,( waiver was high, acute care plan / ER utilization was low?). This data was compared to Intellectual disability population group in nursing home residents. (just providing example of cost comparison)
Morgan Honea: Create greater clarity with phrases – High Risk, HU, High Cost (not the same thing), HU is leading the growing cost and high risks are proxies to identify the HU reasons

Carol Plock: PIAC is concerned with kids prevention, number of adverse childhoods - COPD, depression, drug use, alcohol abuse, liver disease, STD, smoking. The objective measure is to get the screening done to prevent - from evidence based perspective. However, we can’t ask all providers to do the screening to all patients. They do not have the time and resource. The assessment can be addressed as needed. Can research be done to address this?

Mark Ferretti: Identify HU, will allow you to predict the future HU and the factors. First identify the current HU, second identify future HU. Put everyone on the utilizer scale. Identify scale and indicators. Low and moderate utilizers may be reached out in the future – Truven can help identifying with utilization patter, which will give a picture. are we zooming at HU? What characteristics? – then develop criteria for HU.

Morgan Honea: Will compile the feedback and email everyone to help us prepare to present at the PIAC meeting.

5. **Wrap-up (Questions and comments)**

1. Decisions: To work with Truven on methodology per above discussion, what other data resource is available to analyze and identify the HU population groups for the purpose of criteria. Confirm date for the criminal justice strategy presentation for PIAC meeting.
2. Action Items: Take recommendation to PIAC – The proposed date is March or April. Morgan will reach out the PIAC co-chairs.
3. Next meeting: March 2, 2017, 1:00-2:30pm (CHORIO office)

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the Board Coordinator at 303-866-4031 or rahem.mulatu@state.co.us or the 504/ADA Coordinator at hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.