To view the recording of this webinar, please go to this website:

https://vimeo.com/136739078
Program Updates

1. Informing Change Interviews
   • Project Charter Updates

2. Empanelment Webinar Series
   • Part 1: Empanelment Basics – Recording Available Sept 1st
   • Part 2: A Deeper Dive into Empanelment
     September 8th 12:00 – 1:30 p.m.

3. In Person Convening - November 10, 2015
   • San Francisco Bay Area
   • Module 4: Trends, Tools and Technology
Denver Health’s 21st Century Care: Population Health-Informed Primary Care Services

Safety Net Analytics Program
8-18-15

Tracy Johnson, PhD, MA, co-PI, Evaluation Lead
Holly Batal, MD, MBA, co-PI, Clinical Lead
Acknowledgements and Disclaimers

- Core Team, Clinical Teams, IT Team, Evaluation Team, ACS and Executive Leadership (past and present)
- Denver Health’s 21st Century Care project is supported by the Department of Health and Human Services, Centers for Medicare & Medicaid Services, Contract Number 1C1CMS331064.
- The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the U.S. Department of Health and Human Services or any of its agencies.
- The analysis presented was conducted by the awardee. Findings may or may not be consistent with or confirmed by the independent evaluation contractor.
- The Colorado Multiple Institutional Review Board determined this project to be Quality Assurance, Not Human Subject Research.
Improve access and achieve Triple Aim: better care, smarter spending, healthier people

Enhanced clinical services through redesigned health teams (~$9m)
- Clinical pharmacists
- Behavioral health consultants
- RN care coordinators
- Patient navigators
- Social workers
- Specialized high intensity teams

- Enhanced health information technology (~$9m)
  - Population segmentation/patient risk stratification
  - 3M™ Clinical Risk Groups (CRGs)
  - eTouch Services

- Administration and Evaluation (~2m)
  - Rapid Cycle Evaluation NOT Research

CMMI Award
2012
3 years
$19.8 million

Data Notes: Adapted from Rachel M. Everhart, EVALUATION OF A MEDICAL HOME TRANSITIONS OF CARE INTERVENTION IN A SAFETY NET SETTING, Health Services Research PhD Program Thesis Defense. April 24, 2014
21\textsuperscript{st} Century Care: a population health approach to primary care

- Population Segmentation/Risk Stratification:
  - Who
  - How
  - Why
What is Population Health?
Which is the Population of Focus?

- Population Health is “the practice of determining the health and health needs of a population by measuring and reporting [clinical and non-clinical] factors that may influence an individual's health.” Looks for patterns in data to be used to improve health outcomes (U.S. Department of Veterans Affairs)

- DH Public Health = Denver County/region
- DH Managed Care = Health Plan Members
- DH Primary Care Providers = Panel
- DH “Accountable Care Organization” (ACO) Model
  - Primary care patients
  - Managed care patients
  - Frequent users of IP, ED, Urgent Care services
21st Century Care: Population Health “Tiered” Delivery of Enhanced Care Management Services

**Patients MMs**

- **Tier 4**: 10,087 cases, 73% adult, 27% pediatrics
- **Tier 3**: 31,372 cases, 80% adult, 20% pediatrics
- **Tier 2**: 397,463 cases, 82% adult, 18% pediatrics
- **Tier 1**: 640,933 cases, 27% adult, 73% pediatrics

**Baseline PMPMs**

- **Tier 4**: $6,919, Adults: $7,801, Peds: $4,552
- **Tier 3**: $3,035, Adults: $3,449, Peds: $1,410
- **Tier 2**: $560, Adults: $614, Peds: $314
- **Tier 1**: $93, Adults: $137, Peds: $76

**Staffing Model**

- **Multidisciplinary High Risk Health Teams**
  - PN, RN CC, PharmD, BHC, HIT
- **PN BHC HIT**
  - HIT

**Enhanced Clinical & HIT Services**

- High Intensity Treatment Clinics
- Complex Case Management (High Risk Care Coordination)
- Chronic Disease Management
  - Panel Management
  - eTouch Programs

Notes: Baseline period is July 2010 through June 2011. This initial "proof of concept" tiering algorithm was implemented by Milliman using CDPS predictive modeling tool thresholds to define tiers. Tier sizes were pre-determined according to estimated resource capacity. The attributed managed care population was identified through membership files, whereas the fee-for-service population was selected at a single point in time at the beginning of the time period and fixed for the duration. All attributed individuals were tiered. MM: Member months, PMPMs: Per member per month, PN: Patient Navigator, RN CC: Nurse Care Coordinators, PharmD: Clinical Pharmacist, BHC: Behavioral Health Consultant, Health Information Technology: HIT, eTouch: Health Text Messages Programs.

Who Do We Tier?

- All patients who have had a visit to a Denver Health facility in the previous 18 months (includes clinic visits, hospital, ED, urgent care, public health visits, etc.)
- Medicaid, Medicare, CHP Managed Care patients, regardless of whether they have been to DH or not
- Run daily, with full population refreshes monthly

# of Patients

<table>
<thead>
<tr>
<th>Total # of Patients</th>
<th>CMMI Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Patients</td>
<td>Adults</td>
</tr>
<tr>
<td>251,602</td>
<td>163,961</td>
</tr>
<tr>
<td>139,877</td>
<td>71,829</td>
</tr>
</tbody>
</table>

DHHA Confidential
Data Notes: Slide courtesy of Dan Brewer
How Do We Tier?

- Clinical Risk Groups (CRG) is a commercial diagnosis grouper and we considered tiering based on CRG alone

CMMI Adults by CRG Status

1 - Healthy: 26,412
2 - History of Significant Acute Disease: 3,273
3 - Single Minor Chronic Disease: 4,496
4 - Minor Chronic Disease in Multiple Organ Systems: 1,427
5 - Single Dominant or Moderate Chronic Disease: 12,507
6 - Significant Chronic Disease in Multiple Organ Systems: 16,683
7 - Dominant Chronic Disease in 3 or More Organ Systems: 2,041
8 - Dominant, Metastatic and Complicated Malignancies: 558
9 - Catastrophic Conditions: 1,335
How Do We Tier?

- Decided CRG Status alone does not suffice for initial tier sorting
- Needed to include the notion of “actionable patients”
- Drilled down to individual CRG’s which were more clinically meaningful for matching clinical resources to patient need
- CRG Levels are predictive of future patient health and costs

<table>
<thead>
<tr>
<th>Base CRG Description</th>
<th># of Pts.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6100 – Chronic Renal Failure and Other Dominant or Moderate Chronic Disease</td>
<td>5</td>
</tr>
<tr>
<td>6111 – Congestive Heart Failure and Diabetes</td>
<td>14</td>
</tr>
<tr>
<td>6130 – Cerebrovascular Disease and Diabetes</td>
<td>9</td>
</tr>
<tr>
<td>6142 – Diabetes and Asthma</td>
<td>43</td>
</tr>
<tr>
<td>6150 – Advanced Coronary Artery Disease and Other Dominant Chronic Disease</td>
<td>14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Full CRG Description</th>
<th>Avg. Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>61421 – Diabetes and Asthma – Level 1</td>
<td>$5,815</td>
</tr>
<tr>
<td>61426 – Diabetes and Asthma – Level 6</td>
<td>$41,346</td>
</tr>
</tbody>
</table>
## Optimizing Tiering

### Example of Drill-Down Analyses to Inform Tiering Rule Development

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 - Healthy</td>
<td>38</td>
<td>$859</td>
<td>0.00</td>
<td>$9,520</td>
<td>0.00</td>
<td>$32,000</td>
<td>1.00</td>
</tr>
<tr>
<td>2</td>
<td>3 - Single Minor Chronic Disease</td>
<td>1</td>
<td>$3,295</td>
<td>0.00</td>
<td>$0</td>
<td>0.00</td>
<td>$4,847</td>
<td>0.00</td>
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<tr>
<td>4</td>
<td>4 - Minor Chronic Disease in Multiple Organ Systems</td>
<td>1</td>
<td>$4,550</td>
<td>0.00</td>
<td>$0</td>
<td>0.00</td>
<td>$710</td>
<td>0.00</td>
</tr>
<tr>
<td>5</td>
<td>5 - Single Dominant or Moderate Chronic Disease</td>
<td>430</td>
<td>$3,845</td>
<td>0.04</td>
<td>$6,622</td>
<td>0.08</td>
<td>$10,889</td>
<td>0.10</td>
</tr>
<tr>
<td>6</td>
<td>6 - Significant Chronic Disease in Multiple Organ Systems</td>
<td>915</td>
<td>$7,820</td>
<td>0.08</td>
<td>$14,682</td>
<td>0.20</td>
<td>$14,183</td>
<td>0.13</td>
</tr>
</tbody>
</table>

### Base CRG

<table>
<thead>
<tr>
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<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6141 - Diabetes and Other Dominant Chronic Disease</td>
<td>$62,105</td>
<td>1.00</td>
<td>$84,393</td>
<td>3.00</td>
<td>$803</td>
<td>0.00</td>
</tr>
<tr>
<td>6143 - Diabetes and Other Moderate Chronic Disease</td>
<td>$11,542</td>
<td>0.16</td>
<td>$22,256</td>
<td>0.37</td>
<td>$12,136</td>
<td>0.15</td>
</tr>
<tr>
<td>6142 - Diabetes and Asthma</td>
<td>$8,822</td>
<td>0.08</td>
<td>$11,039</td>
<td>0.12</td>
<td>$23,045</td>
<td>0.20</td>
</tr>
<tr>
<td>6145 - Diabetes and Other Chronic Disease Level 2</td>
<td>$6,242</td>
<td>0.11</td>
<td>$11,359</td>
<td>0.16</td>
<td>$10,877</td>
<td>0.11</td>
</tr>
<tr>
<td>6144 - Diabetes and Hypertension</td>
<td>$5,919</td>
<td>0.03</td>
<td>$10,612</td>
<td>0.12</td>
<td>$13,938</td>
<td>0.12</td>
</tr>
<tr>
<td>6270 - Two Other Moderate Chronic Diseases</td>
<td>$1,066</td>
<td>0.00</td>
<td>$3,940</td>
<td>0.00</td>
<td>$2,420</td>
<td>0.00</td>
</tr>
</tbody>
</table>

| 8 - Dominant, Metastatic and Complicated Malignancies | $33,508 | 0.36 | $11,467 | 0.38 | $5,105 | 0.00 |
| 9 - Catastrophic Conditions | $25,302 | 0.59 | $45,214 | 0.38 | $37,637 | 0.38 |
| 3 | $30,800 | 0.61 | $39,678 | 0.62 | $34,587 | 0.56 |
| 4 | $67,999 | 1.79 | $52,404 | 1.07 | $81,615 | 0.89 |

Total | $108,038 | 0.36 | $20,802 | 0.34 | $25,157 | 0.28 |

Citation: Johnson T, Estacio R, Vlasimsky T et al., "Augmenting Predictive Modeling Tools with Clinical Insights for Care Coordination Program Design and Implementation," eGEMS (Generating Evidence & Methods to improve patient outcomes). 2015 (In press.)
Pediatric Patients by CRG

<table>
<thead>
<tr>
<th>CRG Description</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Healthy</td>
<td>58,401</td>
<td>597</td>
<td>135</td>
<td>55</td>
<td>59,188</td>
</tr>
<tr>
<td>2-history of Significant Acute Disease</td>
<td>3,184</td>
<td>86</td>
<td>52</td>
<td>12</td>
<td>3,334</td>
</tr>
<tr>
<td>3-Single Minor Chronic Disease</td>
<td>1,136</td>
<td>1,179</td>
<td>27</td>
<td>13</td>
<td>2,355</td>
</tr>
<tr>
<td>4-Minor Chronic Disease in Multiple Organ Systems</td>
<td>112</td>
<td>3</td>
<td></td>
<td></td>
<td>115</td>
</tr>
<tr>
<td>5-Single Dominant or Moderate Chronic Disease</td>
<td>192</td>
<td>5,839</td>
<td>927</td>
<td>327</td>
<td>7,285</td>
</tr>
<tr>
<td>6-Significant Chronic Disease in Multiple Organ Systems</td>
<td>596</td>
<td>482</td>
<td>230</td>
<td></td>
<td>1,308</td>
</tr>
<tr>
<td>7-Dominant Chronic Disease in 3 or More Organ Systems</td>
<td>2</td>
<td>9</td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>8-Dominant, Metastatic and Complicated Malignancies</td>
<td>1</td>
<td>6</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>9-Catastrophic Conditions</td>
<td>16</td>
<td>81</td>
<td></td>
<td></td>
<td>97</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62,913</strong></td>
<td><strong>8,410</strong></td>
<td><strong>1,650</strong></td>
<td><strong>727</strong></td>
<td><strong>73,700</strong></td>
</tr>
</tbody>
</table>

DHHA Confidential
Data Notes: Slide courtesy of Dan Brewer and Jonathan Block
How Do We Tier?: Using Predictive Modeling and Clinical Insight (Adults)

CRGs (diagnosis grouper) are primary basis for tier assignment

Tier 4
- n=3,266
- CRG 5 (43%)
- CRG 6 (82%)
- CRG 7 (60%)
- CRG 8 (2%)
- CRG 9 (3%)
- Adult High Risk (5%)
- Adverse Birth Outcomes (1%)

Tier 3
- n=7,411
- CRG 1 & 2 (94%)
- CRG 3 (5%)
- CRG 4 (5%)
- CRG 6 (82%)
- CRG 7 (60%)
- CRG 8 (2%)
- CRG 9 (3%)
- Adult High Risk (5%)
- Adverse Birth Outcomes (1%)

Tier 2
- n=27,325
- CRG 1 & 2 (94%)
- CRG 3 (5%)
- CRG 4 (5%)
- CRG 5 (11%)
- CRG 6 (82%)
- CRG 7 (60%)
- CRG 8 (2%)
- CRG 9 (3%)
- Adult High Risk (5%)
- Adverse Birth Outcomes (1%)

Tier 1
- n=31,490
- CRG 1 & 2 (94%)
- CRG 3 (5%)
- CRG 4 (5%)
- CRG 5 (11%)
- CRG 6 (82%)
- CRG 7 (60%)
- CRG 8 (2%)
- CRG 9 (3%)
- Adult High Risk (5%)
- Adverse Birth Outcomes (1%)

Total
- N=69,492

Utilization overrides CRG-assigned tier

Provider Patient Dashboard:

Provider Status:
- 1 - Healthy
- 2 - History of Significant Acute Disease
- 3 - Single Minor Chronic Disease
- 4 - Multiple Chronic Disease in Multiple Organ Systems
- 5 - Single Dominant or Moderate Chronic Disease
- 6 - Significant Chronic Disease in Multiple Organ Systems
- 7 - Dominant Chronic Disease in 3 or More Organ Systems
- 8 - Chronic and Complicated Metastatic Conditions
- Total

Total Charges (Last 12 Months):
- Inpatient: $1,377,866
- Observation: $2,496,262
- Outpatient: $2,060,934
- Emergency Dept: $17,875
- Urgent Care: $57,491

Top 15 Primary Diagnoses:
- Diabetes Mellitus Without Mention of Complication: 146
- Encounters for Other Specified Administrative Purpose: 126
- Unspecified Essential Hypertension: 124
- Low Back Pain: 82
- Major Depressive Affective Disorder Recurrent: 77

Percent of Patients by Age Range:
- 18-35: 56.45%
- 36-45: 29%
- 46-55: 25%
- 56-65: 29%
- 66+: 83

Provider Patient Dashboard: DHHA Confidential
Data Notes: Slide courtesy of Dan Brewer
Data notes: Authors’ analysis of data from the data warehouse of Denver Health. NOTES “Not in original cohort” is people who became super-utilizers after the study period began (members of all other categories were in the original cohort). “Will die” is people from the original cohort who died during the study period; some people who died also permanently or temporarily lost super-utilizer status. “Will lose and not regain status” is people from the original cohort who stopped being super-utilizers and did not regain that status during the study period. “Will lose and regain status” is people from the original cohort who stopped being super-utilizers and did regain that status during the study period. “Continuously met criteria” is people who met the criteria for super-utilizers throughout the study period. Some people classified as “not in original cohort” also died, permanently or temporarily lost super-utilizer status, or both during the study period. However, these super-utilizer status changes were not tracked. Only status changes affecting the original cohort are shown in the exhibit.
Cost Savings Analysis: Why can’t we simply compare utilization/costs of before and after program enrollment?

This natural tendency for high-utilizing patients to become less high-utilizing over time is known as “regression to the mean”.

Charges reduced 44% & admissions reduced 53%, but NO clinical intervention was provided!
Next Steps in Algorithm Development

• Integrate into new EHR (Epic)
• Collect and integrate data to better capture social determinants of health
• Collaborate with clinics to improve relevance and gain traction
Why do we tier?

• Identify populations where it is possible to:
  – Reduce inpatient utilization
  – Reduce frequent ED use
  – Increase primary care visits
  – Improve patient health through care management

• Match groups of patients to resources

• To identify patients appropriate for specific interventions, tiering is necessary but not sufficient – also need a triggering mechanism
How are tiers used clinically?

- Triggering a patient for screening for IOC
- Appear on face sheet – provider and team knowledge
- Appear on worklists – prioritize outreach
- Allocating resources – behavioral health consultants and clinical pharmacists
- Provider referral for high intensity treatment teams
- Adjusting panels
- Interpreting total cost of care
Case example: tiering and triggering for adult high intensity clinical services

- Tiering – defines total population of patients potentially eligible at any given point of time (population segmentation)
- Triggering – determines the exact patient to focus on at the time that the intervention can be applied
- Will use example of aICU
Intensive Outpatient Clinic (aICU)

- Targeted to adults with multiple, potentially avoidable, inpatient admissions within a year
- Serves as the patient’s medical home and has a much smaller panel size
- More robust staffing model – dedicated social worker and navigator, more generous provider, RN, HCP and clerical ratios per patient
- A range of care coordination/care transition services are provided according to a care plan that captures the following domains: Medical, Psychiatric, Medications, Substance Use/Abuse, Social
- Also have contract with MHCD for a HIT mental health team
Qualification for Tier 4 can occur through four means:

1. Assigned according to Tier 4 Base clinical risk group (CRG)
2. Assigned according to 3+ Inpatient Admits in last 12 months
3. Assigned according to 2+ Inpatient Admits in last 12 months and Mental Health criteria
4. 10+ ED visits in last 12 months
Who are Super-Utilizers?

CRGs are primary basis for tier assignment

- Tier 1: n=31,490 (5%)
- Tier 2: n=27,325 (11%)
- Tier 3: n=7,411 (31%)
- Tier 4: n=3,266 (94%)

CRGs are primary basis for tier assignment.

Utilization overrides CRG-assigned tier

- CRGs 1 & 2: (94%) Predictive Model Criteria
- CRGs 3, 4, 5, 6, 7, 8: (5%)
- CRGs 9, 10: (1%)

Adverse Birth Outcomes

- Adult High Risk: (5%)
- Super Utilizers: (40%) <= 3% of adults; 30% of facility costs

Total N=69,492

Super-Utilizer Interventions: Adult High Intensity Teams

CMMI: MHCD ACT Clinic & Denver Health Tier 4 Adult High Risk Clinic

Denver Health - Tier 4 Adult Medical Clinic

MHCD - Accountable Community Treatment (ACT) Clinic

HIGH RISK

Medical Referral:
- 3+ admits
- Exclude: End stage renal disease (ESRD), out of county, commercial

MHCD Referral:
- 2+ admits
- Mental illness diagnosis
- Exclude: out of county
aICU Patient Recruitment

• Need real time patient identification
• Trigger event - when a patient was hospitalized and had index, or subsequent, qualifying admission
• Daily list pushed to IOC on patient admission
• IOC screens for eligibility
• For eligible patients follows patient until discharge to attempt to engage them in care
• More recent iteration - MD rounding in hospital
# IOC Inpatient Transitions Workflow

**When?** Daily at morning team huddles

**Patient Identification:**
- IOC Admit or Report
- Admissions email
- Calls
- Attending/provider referral
- Huddles

**For whom?**
- Establish IOC patients
- New patients

**New patient identified as IOC eligible in PRM through IOC screening process**

1. **In patient evening:**
   - Patients are admit report each morning at huddle.
   - Team determines which patients to visit that day and who will complete the visit.
   - New patient?

2. **In hospital:**
   - Locate patient room using DIM
   - Visit patient in hospital
   - Use standard selection criteria
   - Collect patient initial barriers
   - Screen for and document patient social
   - Obtain and document patient medical history
   - Communicate primary contact information to update insurance

3. **Patient agrees to enroll in IOC?**
   - Notify the patient of the IOC appointment at bedside or by phone
   - Schedule IOC appointment at bedside or by phone
   - Set reminder call for IOC

4. **If scheduled bedside, coordinate with admitting team to get appointment added to discharge instruction:**
   - If scheduled bedside, coordinate with admitting team to get appointment added to discharge instruction
   - IOC appointment is outside of this, follow up recommended timelines?
   - IOC appointment is outside of this, follow up recommended timelines?
   - Follow up with OIS/CMs. PN to ensure that(b) she is aware if it is an IOC, eligible, and to continue with standard transition of care

5. **If scheduled bedside, coordinate with admitting team to get appointment added to discharge instruction:**
   - Identify barriers that led to no show and share information with care team
   - Outreach to patient to reschedule

6. **Place reminder call to patient 2-3 days before scheduled IOC appointment:**
   - PIO call task in PRM

7. **Set reminder call to patient 2-3 days before scheduled IOC appointment:**
   - PIO letter
   - PIO discharge checklist
   - PIO letter 3 attempt

8. **2-3 days prior to appointment to allow for time to arrange transportation:**
   - PIO letter
   - PIO discharge checklist
   - PIO letter 3 attempt

**End**

---

**ICS/CAGI**

1. Review chart and flag report for local patient history and admit.
   - Determine patient room number/location
   - Upon arrival in floor, check in at nurses’ station and speak with patient.
   - Work with RN to determine patient's discharge date.
   - Schedule IOC appointment at bedside or by phone.
   - Discharge date within 3 amount of time?
   - If scheduled bedside, coordinate with admitting team to get appointment added to discharge instruction.
   - Inform patient that you will be following up with them post-discharge to schedule an appointment.
   - Schedule follow-up visit at the IOC and give patient appointment information.
   - Report back to PRM.

2. Communication with patients and family regarding purpose of IOC.
   - Include which doctor to contact and contact info if patient has follow-up questions.
   - Schedule IOC appointment at bedside or by phone.

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Intensity of “reach” varies: face-to-face visit, post-discharge follow-up, clinical screening
Clinical Insights re: Tiering/Triggering

• Tiering – Who needs closer monitoring?
  – Considers medical burden PLUS other factors
  – Social determinants of health, avoidable utilization, possibility for cost avoidance, potential for health improvement

• Triggering – When do we act?
  – Needs to include some measure of patient activation/readiness
  – May be opportunistic (when patient interacts with the system)

• Gaining clinical acceptance for tiering takes clinical involvement in the process – transparency

• Tiering can help risk-adjust primary care panels/allocate staff resources

• However, DH has found using tiers to help match resources to patient need easier for a separate clinic focused on high-risk patients than for similar patients seen in regular primary care

• Population health requires culture change – is that patient “my” patient?
• The contents of this presentation are for internal use only and has not been CMS approved
• Denver Health’s 21st Century Care project is supported by the Department of Health and Human Services, Centers for Medicare & Medicaid Services, Contract Number 1C1CMS331064.
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Contact information:

Holly Batal, MD, MBA  
Co-PI, Clinical Lead  
Holly.Batal@dhha.org

Tracy Johnson, PhD, MA,  
Co-PI, Evaluation Lead  
Tracy.Johnson@dhha.org