CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

1570 Grant Street
Denver, CO 80203

DRAFT

Hospital Transformation Program

Intervention Proposal

I. Background Information

This Intervention Proposal is designed to clearly articulate the scope and goals of proposed transformation interventions aimed at impacting the hospital's selected local quality measures under the HTP. The following questions are meant to assist the state in identifying: the evidence base for each intervention; the need within targeted communities for the implementation of the interventions; and how the interventions will advance the goals of the HTP.

Hospitals will not be required to implement a specified number of interventions. Instead, participation requirements are based on the selection of local quality measures to impact within the five HTP Focus Areas:

- Reducing Avoidable Hospital Utilization
- Core Populations
- Behavioral Health and Substance Use Disorders
- Clinical and Operational Efficiencies
- Community Development Efforts to Address Population Health and Total Cost of Care

Hospitals will be required to address statewide measures for each Focus Area. Hospitals will also be required to select from the HTP list of local measures across the five Focus Areas based on community needs and the goals of the HTP. Each hospital will be required to work on a set of measures equal to 100 points. The number, mix and points per measure will vary according to hospital size, defined by bed count or specialty type:

- Large hospitals (91+ beds) will be accountable for six statewide measures, totaling 60 points and a minimum of four local measures, which will account for 40 points. Points per local measure will equal 40 divided by the number of local measures selected.
- Medium hospitals (26-90 beds) will be accountable for six statewide measures and a minimum of two local measures. If two local measures are selected, statewide measures will total 75 points, and local measures will account for 25 points. Points per local measure will equal 25 divided by the number of local measures selected. If three local measures are selected, then statewide measures will total 67 points and local measures will account for 33 points. Points per local measure will equal 33 divided by the number of local measures selected. If four or more local measures are selected, then statewide measures will then total 60 points and local measures will account for 40 points. Points per local measure will equal 40 divided by the number of local measures selected for four or more local measures.
- Small hospitals (<26 beds) excluding critical access hospitals will be accountable for six measures (statewide or local) to account for 100 points. Points per each measure will equal 100 divided by the number of measures selected.
- Critical access hospitals will be accountable for six measures (statewide or local) and will have their risk for measures reduced by 40%.
- Pediatric hospitals will be accountable for five statewide measures, totaling 50 points and a minimum of five local measures, which will account for 50 points. Points per local measure will equal 50 divided by the number of local measures selected.

- Respiratory specialty hospital(s) will be accountable for four statewide measures and a minimum of four local measures. If four measures are selected then statewide measures will total 56 points and local measures will account for 44 points. Points per local measure will equal 44 divided by the number of local measures selected. If five or more measures are selected, then statewide measures will total 50 points and local measures will total 50 points. Points per local measure will equal 50 divided by the number of local measures selected.

Hospitals have the option to work on local measures beyond the required minimum. This would spread the local measure risk by reducing the points per local measure.

In addition, hospitals have the option to replace a local measure with a statewide priority. Each statewide priority will be worth 20 points and if selected the points for each remaining local measure will be equal to the remaining total required local measure points divided by the number of local measures, greatly reducing the risk associated with those measures.

Hospitals should consult the Measure Scoring Summary, which can be found on the HTP webpage, for more information about measure selection, requirements and scoring.

Hospitals must then design five-year interventions that will impact their selected quality measures.

Hospitals must demonstrate that their proposed interventions will fulfill the goals of the HTP and are evidence-based. They must also justify the selection of each intervention based on the findings of the Community and Health Neighborhood Engagement process, including the environmental scan and feedback.

Each hospital will need to report its own data and submit its own application, but partnerships between hospitals may occur in some instances.

Hospitals may leverage existing resources for interventions, and existing interventions may be considered insofar as they expand or enhance the Department's noted goals and meet the following criteria:

- The hospital must demonstrate that the existing intervention is being selected because it is the best approach for meeting the needs of the community identified during the Community and Health Neighborhood Engagement process.
- The hospital must demonstrate that the intervention can and will be enhanced to meet HTP goals.

In addition to meeting the above criteria, any hospital proposing existing interventions for participation in the HTP will be expected to propose and implement accelerated milestones in the Implementation Plan for such interventions.

This Intervention Proposal must be completed separately for each of the interventions being proposed for inclusion in the HTP. Hospitals must submit interventions that, together, address all of the statewide quality measures and the local quality measures listed in the hospital's response to Question 6 in the Hospital Application.

II. Overview of Intervention

1. Name of Intervention: COE1 - Increase the successful transmission of a summary of care record to a patient's primary care physician (PCP) or other healthcare professional within one business day of discharge from an inpatient facility to home

2. Please use the table below to identify which statewide and selected local quality measures (from the hospital's response to Question 6 in the Hospital Application) the hospital will address through this intervention. As a reminder, each of the statewide and selected local quality measures must be identified for at least one intervention. As such, if this is the only intervention addressing a given Focus Area, all statewide quality measures and all selected local quality measures for that Focus Area must be included in this response. This response should align with the intervention-specific list included in the response to Question 7 in the Hospital Application.

Please note, hospitals are also required to complete the Intervention Proposal below for statewide priorities identified in Question 6 of the HTP Hospital Application.

Please use the unique identification code from the Performance Measures List (which is available on the HTP website) to identify your selected measures. For example, the measure "30 Day All Cause Risk Adjusted Hospital Readmission" should be listed as SW-RAH1.

Response (Please format the response as a numbered list)
1.

3. Please use the space below to describe the intervention and the rationale for its selection. Responses should include:

- A description of the intervention;
- Who will be the target population for the intervention; and
- How the intervention advances the goals of the HTP:
  - ✓ Improve patient outcomes through care redesign and integration of care across settings;
  - ✓ Improve the patient experience in the delivery system by ensuring appropriate care in appropriate settings;
  - ✓ Lower Health First Colorado (Colorado's Medicaid Program) costs through reductions in avoidable hospital utilization and increased effectiveness and efficiency in care delivery;
  - ✓ Accelerate hospitals' organizational, operational, and systems readiness for value-based payment; and
  - ✓ Increase collaboration between hospitals and other providers, particularly Accountable Care Collaborative (ACC) participants, in data sharing and analytics, evidence-based care coordination and care transitions, integrated physical and behavioral care delivery, chronic care management, and community-based population health and disparities reduction efforts.

Response (Please seek to limit the response to 1,000 words or less)
This intervention focuses on increasing the successful transmission of a summary of care record to a patient's primary care physician (PCP) or other healthcare professional within one business day

of discharge from an inpatient facility to home. The intention of this measure is to send the discharge summary via different electronic health records (EHRs). This intervention will include inpatient and non-admitted observation patients. In 2020 alone, our facility saw a total of 48,888 inpatients and an additional 29,780 patients via emergency department visits. By increasing success transmission of records to PCPs, we will increase patient follow up, compliance, and therefore improve patient care.

P/SL plans on leveraging EHR systems to improve the proper routing of care summaries, thereby, reducing less reliable summary routes, including paper, fax, and email transmissions, and the less sophisticated copying of records to CD/DVD. This will necessitate the enhancement of our EHR functionality to achieve these goals. The facility's Health Information Management (HIM) Department, in partnership with representation from our hospitalist stakeholders and clinical informatics teams, will be working with our facility's process improvement experts in the quality department to create workflows to achieve successful record transmission. After workflows are created we plan to engage a local group of PCPs to garner feedback, ideas, and improvement. When the intervention is ready to go live, education will be conducted with various stakeholder groups through multiple channels, including face to face via service line meetings, just in time/at the elbow, and via printed materials (newsletter/flier).

Our intervention must be flexible to take into account the various EHR capabilities of PCP offices. For instance, some PCPs may not be on an EHR or have the ability to set up an interface. While we would prefer to standardize transmission via existing structure (e.g. CORHIO), we may still have to rely on previous methods, like fax, to ensure information is transmitted. It is also likely that as our community, providers, and patients change, we may want to submit more clinical information than initially planned as we begin the intervention. It will be important for us to continue to modify and streamline this process on a regular basis. By participating in this intervention, we are hoping that through increased collaboration, we can improve care among the communities we serve.

4. Please use the space below to describe how the intervention and any selected local quality measures to be addressed by the intervention align with community needs identified throughout the Community and Health Neighborhood Engagement process (including data identified in the hospital's CHNE midpoint and final reports), including but not limited to:

    - How the intervention and any selected local quality measures to be addressed by the intervention were selected based on identified community needs, including how they align with identified significant behavioral and physical health needs and / or service capacity resources and gaps, including related to care transitions and social determinants of health;
    - How the population of focus aligns with identified community needs; and
    - How the proposed intervention will leverage available medical and / or social resources and partners.

Response (Please seek to limit the response to 1,500 words or less)

The CHNE process was utilized to inform our organization of community needs and allowed us to make informed decisions when selecting our proposed measures. Based on this report, we learned that most community partners identified gaps in complex care management and care coordination. One partner shared that "poor communication with and among healthcare organizations" was one of the greatest challenges in the Denver metro region. Moreover, we

heard that the transitions between different sites of care, including hospital discharge transitions were of the utmost importance to improve. Several referral partners, including primary care providers noted that if data was shared, as proposed in this intervention, they could "better coordinate patient care, take over care faster after a patient's discharge, reduce the likelihood of readmission and overutilization, and improve overall patient outcomes."

Because of our metro location and partnership with the unique patient population we serve, the CHNE process identified several core populations:

- Those with significant health care needs, including those deemed high utilizers, mothers with behavioral health needs, and senior citizens;

- Individuals with behavioral health and substance use disorders;

- Other special populations, including refugees, recent immigrants, those without documentation, individuals with low literacy, individuals experience homelessness, children in foster care, and children with special health care needs.

This intervention will address community needs for better communication across the continuum of care from hospital discharge to post-hospital care through the transmission of patient specific information to PCPs. Based on the CHNE process, poor communication was noted as a barrier and concern, and through this process, we strive to improve this communication to reduce overutilization of care, prevent readmission and enhance patient outcomes.

5. Please identify the evidence base (academic, professional or otherwise) related to this intervention's use among the target population by selecting one of the following options:

   (1) Randomized Control Trial (RCT) level evidence
   (2) Best practice supported by less than RCT evidence
   (3) Emerging practice
   (4) No evidence

If you selected option 1, 2 or 3 above, please use the space below to summarize the evidence base (academic, professional or otherwise) related to this intervention's use among the target population. The response should address the intervention's ability to impact the selected local and statewide quality measures identified in Question 6 in the Hospital Application. Please submit the response in narrative form and provide links to any reference documentation (data, citations, etc.).

If you selected option 4 indicating that there is no known evidence base, please explain why this intervention is being proposed regardless.

Response (Please seek to limit the response to 1,500 words or less)
This selected intervention interesects with these statewide interventions:

SW-RAH1: Adult 30-day all cause risk adjusted readmission rate

P/SL has a large population of patients who struggle with access to primary care and specialty services due to few providers accepting Medicaid and a lack of afterhours or weekend services. By transmitting a summary of care directly to PCPs, providers will be notified about their patients

shortly after discharge and will be able to follow up immediately and schedule a follow up. This will break down a barrier of a lack of communication and therefore a lack of timely follow-up with primary care services, which has been identified as a risk factor for readmission.

The World Health Organization (2016) notes that transitions in healthcare create a sense of vulnerability for the patients involved. Communication and coordination during this vulnerable time can lead to problems in structures that provide patient safety. During the transition of care (including hospital to PCP, or PCP to hospital), the following has been noted:

- Patient outcomes: increase in mortality and morbidity; adverse events and delays in receiving treatment/community support, emotional and physical pain;
- Utilization: additional PCP or emergency visits, unnecessary tests, preventable readmissions;
- Experience: emotional and physical pain, patient and provider concerns regarding coordination.

Moreover, a study referenced in the American Journal of Managed Care (2017) revealed that an electronic email-based system formed between hospitals and PCPs resulted in improved provider communication and better patient adoption of 7 day hospital follow up visits. Although we are not relying on a primarily email-based system for information submission, this study reinforces that opening channels of communication from hospitals to PCPs results in multiple levels of satisfaction from providers and patients, and perhaps has the ability to decrease utilization (readmission, ER visits) through better patient attendance at hospital follow up visits.

References:

Chase, J., Oza, K., & Goldman, S. (2017). Email-Based Care Transitions to Improve Patient Outcomes and Provider Work Experience in a Safety-Net Health System. The American Journal of Accountable Care. https://www.ajmc.com/view/emailbased-care-transitions-to-improve-patient-outcomes-and-provider-work-experience-in-a-safetynet-health-system

6. a. Does the focus of the proposed intervention intersect with ongoing initiatives statewide (including, but not limited to those included in the ACC, State Innovation Model and Comprehensive Primary Care Plus)?

☒ Yes

☐ No

b. If yes, please identity the applicable statewide initiative(s): (you may select more than one response from the list below)

☐ Behavioral Health Task Force

☒ Affordability Road Map

☒ IT Road Map

☐ HQIP

☒ ACC

- ☐ SIM Continuation
- ☐ Rx Tool
- ☐ Rural Support Fund
- ☐ SUD Waiver
- ☐ Health Care Workforce
- ☐ Jail Diversion
- ☐ Crisis Intervention
- ☐ Primary Care Payment Reform
- ☐ Other: Polish-Primavera Roadmap (please identify)

Please also use the space below to briefly explain how the hospital will ensure the intervention aligns with the applicable ongoing initiative(s).

Response (Please seek to limit the response to 750 words or less)
The Polis-Primavera Roadmap to Saving Coloradans Money on Healthcare (Affordability Road Map) describes several different initiatives, but the Reward Preventative and Primary Care imperative focuses on this intervention best. One of the tenets of this imperative is the improvement of care coordination and delivery of services designed to meet patient needs through the secure transmission of health information. By participating in this HTP intervention, we are aiming to increase efficiency through hospital to PCP transitions, to improve outcomes and lower hospital prices.

Similarly, the state's IT Road Map notes how communication programs, such as CORHIO, and how if this infrastructure is used, will allow primary care providers to have increased data and patient information transparency, ultimately leading to better patient outcomes. By being part of this intervention, we are will be relying on systems such as CORHIO to achieve program goals.

7. Please use the space below to explain any experience the hospital or any affiliated community partners have had with this type of intervention or target population and how that experience will support the success of the intervention.

Response (Please seek to limit the response to 500 words or less)
P/SL has been transmitting some hospital based information to PCPs, but the existing process has not been (1) consistent among providers as some are not enrolled in our current program and (2) has not been measured to ensure that transmission of patient related information is completed within 1 business day after discharge. We feel that our facility has laid some of this groundwork with room to expand, standardize, build upon and improve this process to meet the intervention.

8. a. Is this an existing intervention in use within the hospital ("existing interventions" are those interventions the hospital has implemented or is implementing on the day it submits the Hospital Application)?

☒ Yes

☐ No

b. If yes, please use the space below to explain how the following criteria for leveraging existing interventions is satisfied (the response may reference answers above):

- The hospital must demonstrate that the use of the existing intervention is the best approach for meeting the needs of the community identified during the Community and Health Neighborhood Engagement process.
- The hospital must demonstrate that the project will be enhanced to meet HTP goals.

Response (Please respond as applicable; Please seek to limit the response to 1,000 words or less)
P/SL has been transmitting some hospital based information to PCPs, but the existing process has not been (1) consistent among providers as some are not enrolled in our current program and (2) has not been measured to ensure that transmission of patient related information is completed within 1 business day after discharge. We feel that our facility has laid some of this groundwork with room to expand, standardize, build upon and improve this process to meet the intervention.

9. a. Will the intervention be a joint effort with another organization (e.g., a Regional Accountable Entity, Local Public Health Agency, a mental or community health center, another community organization or any other external organization)?

☒ Yes

☐ No

Partnerships are not required, but, if the hospital will partner, please complete the remainder of this question and provide the required documentation (see subpart c).

b. If yes, please complete the following chart, including listing the partner organization; listing the type of organization; indicating whether the hospital has previously partnered with the organization; and providing a high-level summary of the expected role of the organization in intervention's leadership and implementation.

Partner Organization Name	Type of Organization	Does the hospital have any previous experience partnering with this organization? (Yes or No)	Organization's Role in Intervention Leadership and Implementation (high-level summary)
Colorado Access	Regional Accountable Entity	Yes	Developing and implementing collaborative discharge planning process with hospital
COHRIO	Health information Exchange	Yes	Ensuring timely and accurate information exchange

c. Please also submit documentation of the partnership with each listed organization. Documentation may be provided separately for each organization listed above and could include: a contract; a memorandum of understanding; a business association agreement; a

Letter of Partnership from the listed organization(s); or similar documentation. If a Letter of Partnership is provided, in it the organization should: (1) acknowledge that it intends to partner; (2) provide a brief description of the organization; (3) express agreement with the planned intervention; and (4) express agreement with the planned role it will have in leadership and implementation of the intervention as expressed above. The letter should be signed by a member of the organization's management and submitted with this application in the same .pdf document. The Letter of Partnership Template can be found on the HTP webpage.