CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

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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: Reduce Hospital Severity Adjusted LOS

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. SW-PH1: Severity Adjusted LOS

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)

The Target Population for this measure is all Medicaid recipients over the age of 18 admitted to North Suburban Medical Center. The methods below will be applied to all of our patients however, not just those insured by Medicaid. Length of stay (LOS) management is critical for improving patient outcomes and patient satisfaction and decreasing overall costs of care. Studies

show a clear correlation between patient hospital days and increased likelihood of hospital acquired infections, medication side effects, and decreased quality of patient care.

Effective and efficient Care Coordination is essential to decreasing overall LOS in a hospital setting. Care Coordination has long been guided by the motto "the right care, in the right place, at the right time, for the right price." Effective Care Coordination efforts to streamline patient throughput begin at pre admission for elective procedures or on admission for a non-elective admission and continue through discharge planning, and follow through to the end of the post-acute care services. Improving Care Coordination and addressing costly LOS issues requires identification of processes that address systemic barriers to care. Length of stay management is challenged by a myriad of factors including medical comorbidities, complex discharge barriers, lack of funding, lack of post-acute care treatment options, and social and economic disparities.

Care Coordination is an essential, proactive approach for appropriately moving patients along the continuum of care and providing continuity among all the services being delivered to the patient both in and beyond the inpatient setting of a hospital. The goals of Care Coordination include proactive management of length of stay, emphasizing patient-centered care and patient choice, ensuring evidence-based care and ensuring appropriate level of care placement.

Care coordination ensures compliance with the CMS Conditions of Participation (42 CFR 482.43) which emphasizes the importance of early identification of patients who are likely to experience adverse health consequences upon discharge in the absence of adequate discharge planning. Proactive Care Coordination involves identification of patients at high-risk for readmission and/or complications, assessment of needs and appropriately removing barriers to discharge. Care coordination and proactive discharge planning can improve patient outcomes and decrease readmissions and length of stay.

North Suburban Medical Center (NSMC)plans to improve patient throughput and thereby decrease risk adjusted LOS by use of the following:

1. Strenghten our MultiDisciplinary Rounds (MDR) model using the Next Gen Analytics for Treatment and Efficiency (NATE) Tempo Tool. NATE was developed by HCA to enhance daily documentation in and utilization of a Barrier Rounding Tool. Daily barriers to discharge for each day are entered into the tool. The NATE application is accessed by all providers in the MultiDisciplinary team. All can see what barriers are in place currently and need to be removed prior to discharge to home or to the next level of care. Expamples of such barriers are Oxygen needs, IV medications, pending lab or test results, pending therapy evals, pending insurance authorization for Post Acute Care (PAC) providers etc. These barriers will be reviewed during the daily MDRs so all of the MDR team is aware of their roles in elimating barriers.

2. HCA developed the Total Readmisison Expert (TREX) tood which stratifies all patients risk for hospital readmission. The Case Management Team at NSMC has access to this tool. The findings of the risk stratification will be incorporated into the MDRs and also into the overall MultiDisciplinary Discharge Plan.

3. NSMC will increase our communication and collaboration with our RAE partners for Medicaid recipients that are in need of services, support, and resources post hospitalization. We will be devoping more efficient means of electronic commuication of patient needs and discharge plans in an effort to work collabortively with the RAEs on patient needs post dishcarge.

4. NSMC participates in the CMS Bundled Payment Care Improvement - Advanced payment initiatives (BPCI-A). To better meet the Post Acute Care (PAC) needs of our patients in the Bundled Payment initiative, HCA, in accordance with CMS guidelines, developed a Plus Care Network which consists of high quality post acute care providers to be used with patient across all insurances, including Medicaid. This Plus Care network will ensure high quality care that will lead to lower hospital readmission rates and therefore ultimately lower costs. Plus Care Network providers have been thoroughly vetted to ensure they are providing quality care for our patients and have entered into contractual agreements with HCA to ensure they continue developing strong working relationships with case management (which includes response time), reducing readmissions, and accepting a variety of patients with diverse needs, including our most vulnerable population: Medicaid recipients.

The interventions described above will be implemented for all inpatients regardless of payer source admitted to Rose Medical Center. In order to improve patient outcomes for our most vulnerable and underrepresented groups, our focus will be on inpatient adults (over the age of 18) who have Medicaid as their primary insurance provider.

The proposed intervention aligns with several HTP objectives

1. This work in this intervention can significantly impact and improve patient outcomes by reducing hospital acquired infections and medication side effects.

2. The proposed intervention may improve patient experience through proactive discharge planning and seamless progression through the continuum of care.

3. Reducing Severity Adjusted Length of Stay may lead to lower costs through effective care coordination and timely transition from the inpatient status to the next apropriate level of care. This will strenghten the partnership and collaboration NSMC has within our facility as well as with our Post Acute Care providers.

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)

North Suburban Medical Center (NSMC) is located in the Northern part of Adams County. The core population includes Medicaid patients with underlying chronic illnesses which include behavioral health conditions and substance use disorders. Many of our patients experience homelessness, poverty, and education and transportation limitations. The CHNE revealed that NSMC serves a

highly diverse Medicaid population who are identified as high-risk as a result of these underlying issues. These high risk patients are often without access to primary care due to education levels preventing understanding of how to access Primary Care, transportation issues, financial concerns, family and work obligations etc. This results in poor health management and enhanced risk of chronic underlying disease processes going untreated over periods of time. The proposed intervention will provide North Suburban Medical Center the opportunity to identify our patients who are at higher risk for longer length of stays and readmissions which will in turn enhance our processes to refer these patients to local community partners to address any deficits which directly impacts their lives, well-being, and health. Our interventions will aim to address these core needs of the community and the Medicaid population we serve.

The Community Health and Neighborhood Engagement assessment revealed the following:

* Families living in the NSMC service area have a lower average household income as compared to families in the Denver Metro area, 35.1 percent of area residents live below the 200 percent of fedreal poverty level.

* 8 percent of individuals living the the NSMC areas are not US citizens. This compares to 7.4 percent in the Denver Metro area.

* 6.8 percent of residents in the NSMC area were unable to find transportation to their doctor's office or the office was too far away.

* Children and adolescents experience homelessness in the NSMC are at a greater than 66 percent increase above that same population in the Denver Metro area.

* Residents with undiagnosed or untreated behavioral health concerns that are driving their care utilization and poor health

*High emergency department utilization, or "mis-utilization" such as using emergency departments for primary care services

* A larger than the Denver Metro average of patients of Hispanic ethnicity (27.4 percent compared to 22.percent)

* Higher than the Denver Metro average of residents are living below 200 percent of federal poverty level (35.1 percent) compared to 31.9 percent

* Higher than Average percent of disabled residents at 9.9 percent vs 9 percent

* Lower percentage of residents with a high school diploma at 10.8 percent compared to 8.6 percent

* Higher than average percentage of non citizens at 8 percent vs 7.4 percent

* Compared to the Denver metro region, NSMC's service area population suffers from higher rates of overweight or obese adults at 66.5 percent of the population. This high risk population experiences more hospitalizations related to stroke, and heart disease.

* This population may also experience food and housing insecurity.

* Transportation to follow-up care was also identified as a challenge for our population.

These high-risk patients drive a high utilization of hospital admissions and increased length of stay due to their untreated medical conditions, lack of primary care and lack of medication adherence. High risk patients may have longer length of stay due to higher acuity for management of ongoing medical conditions. Evidence shows that decreasing over-utilization by high utilizers requires a multi-faceted approach which includes addressing social determinants of health. The North Suburban Medical Center population will benefit from increased navigation of services, increased community resources and management of both social/behavioral and medical needs. North Suburban Medical Center

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)

Best Practice supported by less than RCT evidence:

Literature supports that effective case management programs lead to a reduction in length of stay by applying elements of proactive discharge planning that begins at preadmission for elective admits and at admission for non-elective admits, standard workflows and documentation, consistent multidisciplinary collaboration and strong analytic tools. The length of stay (LOS) is an important indicator of the efficiency of hospital management. Reduction in a patient's length of stay results in decreased risk of infection and medication side effects as well as improvement in the quality of treatment, and increased hospital profit.

The Institute of Healthcare Improvement (IHI) emphasizes the benefit and necessity of Multidisciplinary Team (MDT) Rounds and further describes MDT rounding as the routine meeting of health care members for the purpose of discussing and planning how best to meet the needs of the patient and family through clinically appropriate services and efficient resource use in order to maximize clinical outcomes and patient transition. The transformational focus includes barrier identification which helps to ensure that the patient is getting effective, efficient and coordinated care to increase communication, patient satisfaction and manage hospital length of

stay appropriately. Improvement in patient flow is supported with best practice techniques as reviewed by the Institute for Healthcare Improvement (IHI), which outlines the importance of reducing demand, shaping use, data usage, and strong leadership. The IHI work comes from two decades of research, innovation, and learning about hospital-wide patient flow.

The Joint Commission believes that lack of adequate communication between care providers leads to ineffective care transitions from the hospital to post-acute care or home settings. Care coordination among all hospital and post acute care providers is critical for patient care in order to ensure assessment, planning and referrals for safe discharges from the hospital to continuing care providers. Ineffective care transition processes can lead to adverse outcomes for patients including medication errors, progression of illness, complications, lack of post-discharge follow up and emergency department visits. It can also lead to inappropriate use of resources and financial penalties through reduction in reimbursement from the Centers for Medicare & Medicaid Services (CMS) and other insurers.

The Next Gen Analytics for Treatment and Efficiency (NATE) Tempo Tool, designed by HCA, was created to assist hospitals in improving patient throughput, identifiying discharge barriers and improving clinical efficiency and discharge planning. The tool auto-populates key information from the hospital's electronic documentation system and has predictive modeling capabilities. This tool allows for those involved in a patient's care plan to update information in this tracking system as a way to communicate to all disciplines providing patient care. NATE tempo was piloted in 2014 and has documented success surrounding decreased readmission rates, reduced CAUTI and CLABSI incidents, decreased length of stay, improved management of adherence with sepsis bundles and improved HCAHPS scores.

CITATIONS:

42 CFR § 482.43 - Condition of participation: Discharge planning. Retrieved from https://www.law.cornell.edu/cfr/text/42/482.43

Agency for Healthcare Research and Quality https://ahrq.gov/patient-safety/patients-families/index.html Engaging Patients and Families in their Health Care.

Analysis of Length of Hospital Stay using eletronic health records: A statistical and data mining approach. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5898738/#:~:text=Background,with%20more%20efficient%20bed%20management

Care Management and Reduced Length of Stay: How Leaders Can Connect the Dots. Retrieved from https://www.hfma.org/topics/financial-sustainability/article/care-management-and-reduced-los--how-hospital-leaders-can-connec.html

Institute of Healthcare Improvement. Retrieved from http://www.ihi.org/resources/pages/tools/howtoguidemultidisciplinaryrounds.aspx

Society of Hospital Medicine. Retrieved from https://www.hospitalmedicine.org/clinical-topics/care-transitions/ Advancing Successful Care Transitions to Improve Outcomes

Tempo: Together Everyone Improves Patient Outcomes. St Vincent Hospital.Retrieved from http://www.hpoe.org/MHA_Case_Studies/TEMPOTogetherEveryoneImprovesPatientOutcomes_MHA.pdf

Rutherford PA, Provost LP, Kotagal UR, Luther K, Anderson A. Achieving Hospital-wide Patient Flow .

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: ____ (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)

A goal of the Accountable Care Collaborative (ACC) is to combine the management of physical and behavioral health under one accountable entity and to strengthen the coordination of services among service providers for Medicaid recipients. Under the ACC, Regional Accountable Entities (RAEs) were contracted out. North Suburban Medical Center (NSMC) currently works in

conjunction with the RAE. NSMC will continue to work alongside the RAE with increased communication and collaboration for the HTP intervention described above. Strengthening the coordination of services between NSMC and the RAE will assist in the efforts of reducing length of stay, avoidable hospitalizations, and improving overall patient outcomes. The collaboration with our RAE will also ensure a safe discharge handoff and continuation of much needed services for underserved members of our community.

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)

The Colorado Access RAE receives CORHIO ADT feeds as well as periodic referrals from hospitals. This information allows Colorado Access to risk stratify and target interventions for those members who have complex medical issues. The RAE, upon referral, provides members transitioning from hospital settings to lower levels of care with appropriate transitions of care intervention, including, but not limited to: collaborative patient focused discharge planning; submission of patient referrals that support ease of access to services and remain consistent with identified patient needs; coordination of activities to ensure access to care to decrease risk for readmisison; and exchange of patient information, clinical records, care plan goals, and care coordination activities to promote interdisciplinary service delivery.

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)

The North Suburban Medical Center Case Management Department has a strong care coordination model. The Case Management team is comprised of Social Workers and RN Case Managers. The Case Management team completes a screening and/or Discharge Planning Evaluation on all patients, regardless of payor, to assess for post acute care needs, resource needs, social support. primary care provider, housing, and coordination of services. This process will continue with an enhanced emphasis on high risk patients.

North Suburban Medical Center currently holds MultiDisciplinary Rounds

daily to discuss goals of care for the day, barriers to discharge and what is needed to remove those barriers, and the discharge plan. The goal for this intervention is to better incorporate the use of the Next-gen Analytics for Treatment and Efficiency (NATE) Tempo software. This tool enables the MultiDisciplinary Team to review patient goals, barriers to discharge, and the discharge plan together to improve efficiency with patient throughput, decrease barriers to discharge and improve clinical communication and efficiency.

HCA has created Total Readmission Expert (TREX), a data driven tool to predict a patient's risk for readmission within 30 days. This tool utilizes data from 11 sources including: length of stay, chief complaint code, admission type (inpatients only), emergency admission, attending and admitting physician specialty, procedure code and severity, patient height, weight and BMI, pt gender and age, previous visits in any HCA facility, previous ED visits in any HCA facility. This risk stratification tool populates the case management worklist of patients automatically for all patients. NSMC Case Managers and the MultiDisciplinary Team will enhance their utilization of this tool for all patients.

North Suburban Medical Center will continue to hold InterDisciplinary High Dollar/Long Length of Stay meetings weekly that review patients who meet the financial and LOS criteria for the review by the team. Patients are reviewed for procedures, barriers to discharge, financial needs/concerns, psychosocial needs, and discharge planning.

North Suburban Medical Center Case Managers will maintain the already excellent working relationships with providers of HHC, SNF, LTAC and IRF. This is accomomplishe through sharing of patient information as well as communication about best practices. The development of the Plus Care Network will strenghten these relationships with our post acute care providers and provide more efficient, quality care to our most vulnerable patients that previously were overlooked by community agencies/facilities.

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)

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.