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: Reducing Avoidable Hospitalization Utilization

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-RAH1

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)

- Lower Health First Colorado (Colorado's Medicaid program) cost through reductions in avoidable hospital utilization and increased effectiveness and efficiency in care delivery

- Accelerate organizational, operational, and systems readiness for value based payments

- Increase collaboration between hospitals and other providers, particularly Accountable Care Collaboration (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.

The intervention selected to address Reducing Avoidable Hospitalization Measure entails identifying the number of eligible patients between 18 – 64 years of age with acute inpatient stays during the measurement year that were followed by a unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Our implementation plan will include engaging the RAE and relevant community partners to create collaborative discharge planning processes that intentionally match available resources to appropriate segments and/or risk profiles of the eligible population. We intend to utilize our health information exchange partner, CORHIO, to send the hospitals admit, discharge, and transfer information to the RAEs.

We believe this intervention will advance the goals of the Hospital Transformation Program by decreasing hospital readmissions through risk stratification for readmission potential to drive effective and efficient discharge plans including partnerships with Post-Acute Care (PAC) Providers. This will improve patient outcomes by ensuring integration of care is occurring across the appropriate settings. We will be engaging enhanced collaboration with our community partners via data sharing and analytics, evidence-based care coordination and care transitions, integrated health care delivery, and chronic care management.

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)

CHNE community assessment revealed that Sky Ridge Medical Center has a population of patients without access to primary care and specialty services due to few providers accepting Medicaid and lack of afterhours or weekend services. Medicaid patients who present through the emergency department with no PCP is approximately 33%. Many times these patients are using the emergency department for primary care. Assisting patients in obtaining a PCP and/or giving resources to the patient, will decrease emergency room utilization.

Lack of timely follow-up with primary care services has been identified as a risk factor for readmission. Case Management will assist patients in either helping to make follow-up appointment or give resources so the patient can schedule a follow up appointment. Consistent

care will reduce emergency department utilization and lower the acuity of patients admitted to hospital. Ultimately, having a physician to follow up with will decrease readmissions.

CHNE identified transportation to follow up care as a challenge for our population. Public transportation is challenging in Douglas County. As the RTD light rail extends into Douglas County, transportation will become easier for the high-risk Medicaid population to have transportation to follow-up appointments. Sky Ridge will also enlist community partners to assist in transportation issues for our patient population.

Senior population lacks resources and tools to manage complex healthcare system which can contribute to need for readmission. Sky Ridge is increasing available handouts and resources to give to our patient population to assist in meeting the patient's healthcare needs. Case management can also arrange with community partners to provide in-home social work education to assist in navigating the healthcare system.

Sky Ridge is collecting resources for prescription assistance. This information will be provided to patients who are struggling to afford their medications. The senior population often struggles with understanding their at-home medications which contribute to making medication errors and readmissions. Sky Ridge provides medication education before discharge in the hospital. Sky Ridge will also use community partners to provide in-home education and clarification of medications that should be taken at home.

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)

2. Best Practice: Hospital readmissions are costly for payors, patients and hospitals. Hospital Readmissions and how to avoid them has been studied extensively in the past several years.

In 2001, the Institute of Medicine (IOM) reported that, patients receive little information on how to care for themselves, when to resume activities, what medication side effects to look out for, and how to get answers to questions at discharge. This can result in the conditions of many patients worsening. These patients may then be readmitted to the hospital. The IOM stated that nearly one-fifth of fee-for-service Medicare beneficiaries discharged from the hospital were

readmitted within 30 days; three-quarters of these readmissions--costing an estimated $12 billion a year

The Hospital Readmissions Reduction Program (HRRP) was created by CMS in 2010 under the Affordable Care Act to reduce the number of preventable Medicare readmissions. CMS launched HRRP in fiscal year 2013, and hospitals began to face financial penalties for high rates of 30-day readmissions for patients who'd been hospitalized with pneumonia, heart attack, or heart failure.

In 2011, The Association for Healthcare Research and Quality (AHRQ) reported that Medicare had the largest share of total readmissions (55.9 percent) and associated costs for readmissions (58.2 percent). Medicaid had the second largest share of total readmissions (20.6 percent) and represented a lower share of associated costs (18.4 percent). Overall, readmissions resulted in hospital costs reaching $41.3 billion for patients readmitted within 30 days of discharge

In a report by Health Affairs in 2011, ineffective care transitions following a hospitalization increase the rates and costs of hospital readmissions and accounted for $25 to $45 billion in wasteful spending

The Joint commission believes that lack of adequate communication leads to ineffective care transitions from the hospital to post-acute care or home settings.

A Patient Experience study showed that failing to include patients in the discharge process results in higher hospital readmission rates. Patients who reported that they were not involved in their care during the original hospitalization were 34 percent more likely to experience a readmission. In addition, patients who did not report receiving written instructions for discharge care were 24 percent more likely to be readmitted.

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), and 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.

Sky Ridge Medical Center plans to continue to reduce our readmission rates especially in this most vulnerable population. We will incorporate patient and family education about continuing care into our discharge processes.

CITATIONS:

1. Health Affairs, Health Policy Brief, Improving Care Transitions, Rachel Burton, September 23, 2012

   https://www.healthaffairs.org/do/10.1377/hpb20120913.327236/full/

2. RevCycle Intelligence, Value Base Care News, Jacqueline LaPointe

https://revcycleintelligence.com/news/3-strategies-to-reduce-hospital-readmission-rates-costs

3. The Joint Commission, Hot Topics in Healthcare, Transitions of Care

https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/hot_topics_transitions_of_carepdf.pdf?db=web&hash=CEFB254D5EC36E4FFE30ABB20A5550E0

4. Agency for Healthcare Research and Quality (AHRQ) Statistical Brief, April 2014

https://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf

5. Patient Engagement HIT, Patient Engagement in Follow-Up Reduces Hospital Readmission, Sarah Health. August 2017

https://patientengagementhit.com/news/patient-engagement-in-follow-up-reduces-hospital-readmission

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)

Collaboration between Sky Ridge Medical Center and Colorado Access and RAE to establish PCP's. This partnership will also help to identify available resources in the community that will assist patients with follow up needs. This holistic view of patient care will help ensure that patients' needs can be met after an acute hospitalization.

This initiative intersects with The Primary Care Payment Reform program was created to increase access to high-quality primary care. This legislation created a Primary Care Collaboration that has been charged with making recommendations on how to achieve high-quality primary care as well as provide a framework to use tele-health as a primary care option. Tele-health has been used more in the last year since the Covid-19 pandemic began and is showing to have a lot of benefits. This is useful when patients are having difficulties finding a PCP, have transportation issues and need to discuss medications that they are taking at home.

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)

Historically the hospital has collaborated well with Skilled Nursing facilities (SNF, Long Term Acute Care providers (LTAC), Home Healthcare Agencies (HHC) and Inpatient Rehab facilities (IRF). Sky Ridge Medical Center intends to extend our collaboration for post-acute care services with the RAE to ensure follow up PCP visits and be arranged and maintained and patients have access to necessary medications and treatments. Colorado Access (COA) receives CORHIO ADT feeds as well as periodic contacts from hospitals. This information allows COA to risk stratify to target interventions for those members who have complex medical issues. The COA care management team provides members transitioning from hospital settings to lower levels of care with appropriate transitions of care intervention, including, but not limited to:

a. Collaboration with hospital staff to uphold timely and member-focused discharge planning;

b. Development of member-driven care plans that incorporate current member status and needs, interdisciplinary team input, and historical clinical information;

c. Submission of member referrals that support ease of access to services and remain consistent with identified member needs;

d. Care coordination activities designed to ensure sustained member access to care and reduce risk for future hospitalization;

e. Exchange of member information, clinical records, care plan goals, and care coordination activities to promote interdisciplinary service delivery;

f. Follow up with member, provider, and hospital team members to ensure follow through with treatment activities and member success

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)

As mentioned above, Sky Ridge Medical Center Case Management staff maintain excellent working relationships with providers of HHC, SNF, LTAC and IRF. There is sharing of patient information as well as communication about best practices. Home health care can be especially useful when there are transportation issues and confusion about home medications.

Case management identifies patients who have post-acute care needs. Resources are given to patients to make follow-up appointments but Medicaid PCP's are challenging to find in the community. Most Medicaid PCP's are full. Specialty care is even more difficult to find. Resources are given so the patient can continue their search after discharging from the hospital.

Sky Ridge has been participating in the Douglas County Health Alliance to form partnerships and learn about additional resources that can be offered to our Medicaid high-risk population.

As stated before, we believe this intervention will advance the goals of the Hospital Transformation Program by decreasing hospital readmissions through risk stratification for readmission potential to drive effective and efficient discharge plans including partnerships with Post-Acute Care (PAC) Providers. This will improve patient outcomes by ensuring integration of care is occurring across the appropriate settings. We will be engaging enhanced collaboration with our community partners via data sharing and analytics, evidence-based care coordination and care transitions, integrated health care delivery, and chronic care management.

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		Yes	Colorado Access (COA) receives CORHIO ADT feeds as well as periodic contacts from hospitals. This information allows COA to risk stratify to target interventions for those members who have complex medical issues. The COA care management team provides members transitioning from hospital settings to lower levels of care with appropriate transitions of care intervention

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.