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-RAH 1: 30 Day All-Cause Risk Adjusted Hospital Readmission

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)

Hospital readmission rates at Rose Medical Center are impacted by a variety of factors including medical and social conditions our patients are experiencing. Multipe studies on hospital readmissions state that targeted care coordination efforts before discharge is the critical factor on preventing readmissions, especially for patients with multiple chronic conditions. The most

successful plans that reduce readmissions include collaborative discharge planning, patient/family education, and follow up care (Jackson et al. 2013).

Our implementation plan for the readmission intervention will include:

Utilizing the HealthOne risk stratification tool TREX (Total Readmission Expert) for all admissions, and increasing our collaboration with our RAE partners for "high readmission risk" Medicaid recipients that are in need of services, support, and resources post hospitalization.

In our collaborative efforts with our community partners, we intend to use our health information exchange partner, CORHIO, to send the hospitals admit, discharge, and transfer information to the RAEs.

Rose Medical Center has also been selected to participate in the bundled payment initiatives (BPCI-A). As an added benefit from the bundled payments model (which only focuses on Medicare recipients) HCA developed a Plus Care Network which consists of high quality post acute care providers. It is anticipated the Plus Care Network will positively impact our Medicaid recipients in need of post acute skilled services. 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.

We believe this intervention will advance the goals of the Hospital Transformation Program by decreasing hospital readmissions through risk stratification for readmission potential which will then drive effective and efficient discharge plans. We anticipate this collaborative measure will strenghten our partnerships with our Post-Acute Care (PAC) providers. We also anticipate this intervention will improve patient experience and quality care through proactive discharge planning and seamless progression through the continuum of care.

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)
This measure aligns with Rose Medical Center's CHNE (Community and Health Neighborhood Engagement) in the following ways

The CHNE survey revealed that Rose Medical Center serves a population of patients who don't have access to a primary care and/or specialty services due to very few providers accepting Medicaid and the lack of after-hours or weekend services. This leads to poor health management and enhanced risk of chronic underlying disease processes which remain untreated for long periods of time. These high risk patients drive a high utilization of hospital admissions due to their untreated chronic conditions, lack of primary care and lack of medication adherence.

This population may also be underserved in their DME (durable medical equipment) needs, such as oxygen, other medical assistive ambulation devices and transportation to and from appointments. In the Rose service area, 6.4 percent of residents were unable to find transportation to their doctor's office or the office was too far away. This rate increases to 8.6 percent in Denver County and decreases to 3.7 percent in Arapahoe County.

This population is also experiencing food and housing insecurity and may be struggling with unemployment.

The senior population in particular was identified as a vulnerable population that is frequently lacking in resources and due to their frail and unique medical needs, often lack the tools needed to navigate the complex health system thus leading to readmissions.

Pregnant and birthing mothers were identified as high risk for not getting their overall health needs met; especially women of color and low-income women thus contributing to readmissions.

High risk patients have longer length of stay due to higher acuity for management of ongoing medical conditions.

Compared to the Denver metro region, Rose's service area population suffers from higher rates of childhood obesity (16.5 percent) and adult obesity (34.2 percent). Relatedly, the population experiences more hospitalizations related to stroke, heart disease, acute myocardial infarctions, and congestive heart failure than the Denver metro population.

The population around RMC would benefit from increased navigation of services, increased community resources and management of both social/behavioral and medical needs.

The proposed intervention will provide Rose Medical Center with the opportunity to capture our most vulnerable patients via the risk stratification/classification process, and refer our high readmission risk patients to local community partners to address any deficits which directly impacts their lives, well-being, and health.

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 RTC evidence.

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 insufficient information on how to care for themselves, don't know when its safe to resume physical 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 and these patients are the ones at highest risk of being readmitted to the hospital. The IOM stated that nearly one-fifth of 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 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.

Another successful study completed in North Carolina focused on care transitions as an influential factor for Medicaid patients with chronic conditions. This study found that patients who received transitional care were 20 percent less likely to experience a readmission during the following year. Benefits of the care transition interventions were greatest among patients with the highest readmission risk. One readmission was averted for every six patients who received transitional care services and one for every three of the highest-risk patients. This study suggests that targeted care coordination interventions effectively reduced hospitalizations for high-risk populations.

HCA has created the 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 admissions, attending and admitting physician specialty, procedure code and severity, patient height, weight and BMI, patient 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. TREX is also used in interdisciplinary rounding to guide discussions with providers regarding specific readmission risks, and to devise actions that can mitigate these risks. Case Management will use TREX to identify their highest risk patients and collaborate with their RAE's and community partners to provide the resources and critical follow up care this population needs.

CITATIONS:

Agency for Healthcare Research and Quality (AHRQ) Statistical Brief, April 2014. Retrieved from https://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf

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Journal of Hospital Medicine, From Discharge to Readmission: Understanding the Process from the Patient Perspective, Jessica Howard-Anderson, June 11, 2016. Retrieved from https://www.journalofhospitalmedicine.com/jhospmed/article/127428/patients-perspective-readmissionsllaborations with community partners to decrease overall readmissions for our at risk patients.

Patient Engagement in Follow-Up Reduces Hospital Readmission, Sarah Health. August 2017. Retrieved from https://patientengagementhit.com/news/patient-engagement-in-follow-up-reduces-hospital-readmission

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The Joint Commission, Hot Topics in Healthcare, Transitions of Care. Retrieved from https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/hot_topics_transitions_of_carepdf.pdf?db=web&hash=CEFB254D5EC36E4FFE30ABB20A5550E0

Transitional Care Cut Hospital Readmissions For North Carolina Medicaid Patients With Complex Chronic Conditions. Jackson et al. 2013. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0047 Patient Engagement HIT,

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)

Two goals for the accountable care collaborative is to combine the management of physical and behavioral health under one accountable entity and to strenghten the coordination of services among service providers for Medicaid recipients. Under the ACC, RAE's (regional accountable entities) were contracted out, which Rose Medical Center currently works alongside, and will continue to work alongside for the HTP interventions described above. Strenghtening our coordination of services together will assist in the efforts of reducing avoidable hospitalizations, reducing length of stay and improving overall patient outcomes. The collaboration with our RAE's 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)
Historically the hospital has collaborated well with Skilled Nursing facilities (SNF), Long Term Acute Care providers (LTAC), Home Health Care Agencies (HHC) and Inpatient Rehab Facilities (IRF). With the development of the Plus Care Network (a side product of bundled payments) we anticipate even greater care coordination efforts that will improve patient care.

Rose Medical Center intends to extend our collaboration for post-acute care services with our RAE partners to ensure follow up PCP visits and be arranged and maintained and patients have access to necessary medications and treatments, including transportation services. Colorado Access (COA) currently receives CORHIO ADT feeds as well as direct referrals from Rose Medical Center. 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, Rose Medical Center case managers maintain excellent working relationships with providers of home health care, skilled nursing facilities, long term care hospitals and inpatient rehab facilities. There is sharing of patient information as well as collaboration regarding best practices.

Rose case managers are also currently utilizing the TREX platform but standardization of the process is what will enhance the goal of HTP. Using TREX, a risk classification tool, will allow case management to identify "high risk" medicaid recipients and engage in collaborative partnerships with our RAE, post acute care facilities/agencies, and other community partners to better provide for our most at-risk patients who are in greater danger of readmitting due to their chronic conditions and lack of support or resources withouth this intervention.

In addition to standardizing our process and strenghtening our partnerships with community partners, we will also continue incorporating patient and family education into our discharge processes.

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.