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: SW-PH1: Severity Adjusted Length of Stay (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.

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 scientifically proven interventions selected by HCA hospitals to reduce length of stay include daily rounds on barriers to discharge and an electronic tracking system that identifies these barriers in real time. These interventions will be implemented hospital wide and will focus on all patients regardless of their insurance. This program will identify both medical and social barriers

to discharges upon admission, which will allow the treatment team to address these barriers at the beginning of the patient's care. Thirty percent of P/SL's patients have Medicare and are some of the most vulnerable individuals, at risk for readmissions and longer hospital stays. We are confident that these interventions will prioritize this population's medical and social needs and as a result improve care and reduce unnecessary hospital days.

The NATE Tempo Tool is designed to assist facilities in improving patient care throughout our healthcare system by identifying discharge barriers, 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 members of the patient's care team to communicate using real time updates. During morning rounds, the Case Manager on the unit, in conjunction with the Charge Nurse, will update the tracking system with discharge goals and barriers for that day. Using NATE, the team and patient know the required needs to be met for hospital discharge.

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)
Participating HCA Hospitals service a highly diverse Medicaid population. This population is identified as high-risk for hospitalization as a result of socioeconomic status, education level, language barriers, access to resources, serious behavioral health disorders, substance use disorders, and/or significant physical health concerns. There are many discharge barriers we face with this population because Medicaid covers limited outpatient services, putting this population at a higher risk for longer hospital stays and higher readmission rates. By identifying and focusing on patient barriers early during an inpatient stay through NATE, we can identify patient discharge needs and accurately and efficiently reflect them to the multi-disciplinary care team. By conducting our SIBR rounds, we can effectively communicate and collaborate across disciplines and directly involve the patient and/or family in shared decision making. This better allows for our at-risk patients to have a voice in their care planning and helps the care team identify barriers to discharge and access to services.

Medicaid is a great program that offers many opportunities to indigent individuals, however, there are many programs that Medicaid does not cover. First, Medicaid pays for outpatient substance use programs but does not cover inpatient substance use programs, which is the level of treatment many of our patients require. Medicaid also doesn't cover rehab (physical and occupational therapy) in a skilled nursing facility. This is one of the biggest barriers we face with this population and is directly related to greater lengths of stay and readmissions. If our

treatment team cannot safely discharge a patient home because they require additional daily physical therapy, we are responsible for working with the patient in the hospital until they can safely discharge home with home health care. Although Medicaid does pay for home health, we often struggle to find an accepting agency because Medicaid pays these agencies at a much lower rate than other insurers. These patients also have higher needs and a greater risk of getting readmitted, which lowers the home health agencies rating. The new barrier documentation system, NATE, will identify these barriers on admission and focus on this population's discharge needs upon admission to the hospital. The use of the Nate tool, combined with effective SIBR rounding processes, will aim to reduce avoidable delays in discharge and lower our overall legth of stay. Additionally, we have multiple stakeholders (home health agencies, skilled nursing facilities, and acute rehabs) who are committed to our case management team and who have agreed to take part in the Hospital Transformation Program to better serve Medicaid patients in the community.

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)

Unnecessary hospitalization often leads to patients deconditioning, hospital acquired illnesses, increased risk for mortality, and financial risks to both the patient and the hospital. Hospitals worldwide are focusing on increasing communication between interdisciplinary teams by developing electronic systems that track length of stay and barriers to meet that date. There is also a major focus on increasing mobility for patients who are identified as at risk for deconditioning, which is also directly related to increased length of stay. This comprehensive review of evidence-based studies supports the interventions that P/SL is using to reduce length of stay in order to ensure better outcomes for both the patient and the hospital. Based on the amount of research done on these specific programs, we are confident in our decision to implement these interventions into our daily assessment and treatment with patients in order to increase satisfaction and reduce length of stay.

Hospital tracking systems, like NATE, are used to paint the picture of the patient's case, including medical, physical, mental, and social issues, which may play a part in their course of treatment and hospital stay. In a needs assessment conducted by Patel, Morduchowicz, and Mourad, the authors found that the four biggest barriers to early discharge include 1) lack of

communication between nurses, case managers, and teams about discharge planning; 2) obtaining home services, equipment, and oxygen first thing in the morning; 3) arranging transportation to facilities earlier in the morning, and 4) communicating discharge expectations with patients and family members. This same study found that by developing and implementing a web-based dashboard that provides real-time discharge by noon, they had a significant decrease in average length of stay by 0.28 (2017). California HealthCare Foundation argues that in order for this program to be effective and reduce length of stay, information needs to be entered as the patient is admitted to the emergency room or for surgery and is updated in real time throughout their hospital stay (2011).

Another study took the barrier tracking program a step further and recommended that the patients have a tracking system attached to them or their bed, like hospital equipment, in order for the care team to know when a patient is in a procedure, so the team can start preparing for the patient's next step toward discharge (Lewis, 2000). For example, if the patient is needing a stress test in order to be discharged, the nurse will be alerted as the patient is being taken to the procedure and when the patient's procedure is completed, so that the nurse and others involved in the patient's discharge can focus on the remaining barriers that affect discharge. To the reader this may sound extreme, however, Susan Lewis (2000), puts this in perspective by using CSC calculation based on CDC data on average length of stay in the United States, and concludes that reducing the average length of stay by four hours is equivalent to increasing available hospital beds by ten. The progressive barrier tracking systems that hospitals are creating can be accustomed to the patient population they serve to better fit the needs of the patient's and their environment.

Fortunately, there was more evidence in studies that showed positive outcomes to electronic systems that track barriers to discharge over studies with no changes or increase in length of stay. In one study, a VA Hospital in Seattle Washington interviewed a treatment team in order to identify the main drivers behind length of stay in their hospital and reviewed discharges for 6 weeks as a baseline assessment. Their intervention included structured multidisciplinary rounds with an electronic tool that was developed to highlight critical information on each patient consistently (Meo, Wilson, Powers, Magbual, and Miles, 2018). The goal of the electronic system was to update the team in real time, idenitfy the expected discharge date, and identify what needed to be achieved in order to hit the goal. The outcome of this study showed a decrease in length of stay by 1.4 days and an improvement of 21.1% (Meo, Wilson, Powers, Magbual, and Miles, 2018).

References:

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Mccullagh, Ruth & Dillon, Christina & Dahly, D & Horgan, Frances & Timmons, Suzanne. (2016). Walking in hospital is associated with a shorter length of stay in older medical inpatients. Physiological Measurement. 37. 1872-1884. 10.1088/0967-3334/37/10/1872.

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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 completed social needs screening early during a patient's hospital stay can identify discharge barriers. By addressing social needs early, the care team can address concerns and problems and eliminate discharge challenges. The patient can then be discharged when medically cleared, decreasing length of stay, cost, and change of readmission.

On November 8th, 2017, the Colorado Governor's office approved Colorado's Health IT Roadmap, which aims to reduce healthcare costs, provide better care, and improve health care for all of Colorado. The three biggest initiatives that intersect with the statewide measure to decrease length of stay, includes, increasing communication among stakeholders, improve consumer engagement, empowerment and health literacy; and develop approaches for making health analytics accessible and affordable. While this plan doesn't directly impact our interventions to reduce length of stay, it does have a major influence on discharge planning with our community partners and our patients. First, having access to patient's past medical records in real time will allow the treatment team to better identify past treatment, past barriers, and possible new barriers. It will reduce trial and error and allow us to provide better continued care. Then, this also streamlines referrals to our stakeholders and those involved in the patients past and future care, which reduces the chances for rehospitalization. Last, allowing patients to have access to their medical records electronically allows them to better manage their appointments and medications. Our patients with Medicaid are typically more vulnerable and have an increased risk of readmission, we feel that by improving connection and communication can promise them better outcomes.

Another statewide initiative that correlates with reducing hospital length of stay is the Accountability Care Collaborative. The goal of this program is to improve member health and reduce costs by strengthening coordination of services between health care systems and Medicaid participants. Seven Regional Accountable Entity contracts have been created based on services area to ensure that Medicaid members have access to all necessary services once discharged from a hospital. Care Coordinators through the assigned RAE will connect the patient to community resources, help them understand their benefits, help them get behavioral or physical health services, find primary care providers or specialist, schedule transportation for medical and behavioral health appointments, coordinate communication between the different providers, give patients information about health and wellness topics, and help them understand the medication they are taking. By having this professional assist the patient in navigating the many systems in the community, the patient's treatment team feels more secure about discharging the patient's home on the day they are medically stable.

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 currently uses SIBR rounds as part of the Accountable Care Unit (ACU) Model to address each patient's care plan and identify barriers to discharge. This model has been implemented on med/tele, med/surg, ortho and spine units in the Adult tower. The four pillars of ACU are a geographic cohorting of physicians, nurses, and patients (creates a unit-based team), structured interdisciplinary bedside rounding (SIBR), partnered physician-nurse leadership of that unit, and outcomes analysis at the unit level. SIBR rounds, when conducted effectively are scripted and standardized, time conscious (less than 3 minutes/patient), generate actions to progress care in real time, provide purposeful handoffs between participants, and provide meaningful narrative of care to the patient. The ACU model has been shown to effectively increase quality of care, patient safety and reduce overall cost of care. Outcomes include a reduction in mortality rates, 30 day readmissions, length of stay, and average cost per patient case. Other units within PSL include interdisciplinary rounds among care team members to coordinate the plan for the day, address patient questions and concerns, and identify barriers to discharge early in the patient's stay.

The hospital or any affiliated community partner, such as the RAE, does not have any experience with the intervention as the collaborative discharge planning process does not currently exist. However, the RAE has provided the following prior experience with this target population, and based on this experience, it will support the success of our future initiative. 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

Colorado Access manages behavioral health utilization closely for ensuring that members with behavioral health needs are treated at the lowest level of care necessary for safety and efficacy. The behavioral health care management team also work with hospitals and outpatient providers to enable seamless care for the member. Currently, Colorado Access efforts have been aimed at transition from inpatient care. Colorado Access does not receive timely notification of emergency department visits.

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 practiced different ways of doing morning rounds with physician and treatment team, however, many of these programs were not successful, and therefore we continue to modify the structure of rounds and communication and action plan regarding patient barriers. Our most successful format for rounds is SIBR rounds. During SIBR rounds, our multidisciplinary care team performs bedside rounding and each member of the care team reports out to the patient/family. The team identifies anticipated plan for the day, goal for discharge, and patient/family is allowed to ask questions. This format for rounds was put on hold during the 2020 COVID pandemic and we recently re-initiated SIBR rounds to resume on a select number of units, while also protecting our most vulnerable populations. Our barrier electronic documentation system (NATE) is fairly new and went live July 2020 on a limited number of units. As of February 8, 2021, all of our Adult Tower units are officially using this system but because the program is so new we are constantly making changes that fit our hospitals needs to better track barriers.

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)
24/7 Avare Healthcare (Denver South)	Home Health Agency	Yes	Assist with discharge planning, providing home PT/OT/SP/RN/CNA
Namaste Home Health	Home Health Agency	Yes	Assist with discharge planning, providing home PT/OT/SP/RN/CNA
Team Select Home Care	Home Health Agency	Yes	Assist with discharge planning, providing home PT/OT/SP/RN/CNA
Kindred Hospital	LTAC	Yes	Assist with discharge planning, provide PT/OT/24 hour RN/24 hour physician for complex medical care for patients who are not appropriate for SNF or IRF level of care.
Spalding Acute Rehab-P/SL	Acute Rehab	Yes	Assist with discharge planning, provide aggressive inpatient PT/OT/ST/24 hour RN for patients who are not safe to return home
Sloans Lake Rehabilitation	Skilled Nursing Facility	Yes	Assist with discharge planning, provide long-term care for patients who are not safe to discharge home and who require more than 30 days in a treatment center.
Briarwood Health Care Center	Skilled Nursing Facility	Yes	Assist with discharge planning, provide long-term care for patients who are not safe to discharge home and who require more than 30 days in a treatment center.
St. Paul Health Center	Skilled Nursing Facilities	Yes	Assist with discharge planning, provide long-term care for patients who are not safe to discharge home and who require more than 30 days in a treatment center.
The Denver Hospice Compassus Hospice Agape Hospice	Home/inpatient hospice, GIP hospice	Yes	Assist with discharge planning, provide end of life care to patients who have a poor prognosis.
Colorado Coalition for the Homeless	Respite bed, homeless patients	Yes	P/SL with partnership and collaboration for contracted beds at Respite shelters in the community.

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)
			Provide medical respite bed for homeless patients who need home nursing services upon DC.
Intelliride	Transport company	Yes	Provide transportation to and from medical appointments to reduce re-hospitalization and length of stay (Medicaid patients)
Regional Accountable Entity (RAE)	Resource Center for Medicaid patients	No	Coordinate discharge care between hospital and patient/family.
Colorado Access Care Manager	Care Coordination Services	Yes	Coordinate discharge care between hospital and patient/family.

Documentation: Health One is expanding our health information exchange partner, CORHIO, as well as Navi Health, to allow referrals to these entities promptly and securely. Our community partners have been educated on these programs and encouraged to become members of these programs to ensure appropriate use of sharing medical records.

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.