CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

1570 Grant Street
Denver, CO 80203

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: EHR Enhancement of Summaries of Care

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. COE1: EHR Enhancement of Summaries of Care

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 intervention selected to address the transition record to PCP within one business day entails increasing the successful transmission of a summary of care record to a patient's primary care physician (PCP) or other healthcare professional within one business day of discharge from an inpatient facility to home on all patients, both inpatient and observation status. The goal is to

send the discharge summary via Epic to the intended provider, regardless of the EHR, within one business day. In 2020, BCH saw 5,5562 inpatients and 3,477 observation patients. In addition, 416 patients were seen in our Inpatient Behavioral Health Unit. We have an opportunity to utilize our Epic system to make a greater impact on these patient's healthcare journey across the continuum by optimizing the push of our Transition of Care Summary records to all outpatient providers and PCPs.

BCH will leverage Epic to increase our capability of sending plan of care summaries. We hope to decrease other routes of communication that can be less reliable including fax, scanning, e-mail, discs, etc. Currently, we are sending plan of care summaries via fax or Epic to our Behavioral Health community partners. This is a manual process at times and the team must track the delivery of these summaries daily. The lack of efficiency can be cumbersome, and we hope to create a more automatic workflow that will enhance efficiency and decrease errors. We will work towards the goal of utilizing Epic as a primary source for sending plan of care documents. The Case Management team will work with BCH leaders and Epic IT analysts on improving this functionality and developing education for staff. These workflows will need to be vetted through other specialists and staff within the organization including Admin, Quality, Unit Coordinators, Care Management, HIM, and our BCH Primary Care Clinics as well as other community providers.

BCH IT will be taking the lead on this electronic intervention to enhance the product and process of sending the summary of care record via Epic. The intended recipients of this document include the patient's individual PCP, or other healthcare providers, within one business day following discharge from an inpatient facility during the performance year. We will develop a robust plan for monitoring improvement of this process as well as to educate the PCP clinics and other ambulatory supportive services. The Health Informatics team will be crucial in identifying the ability to set-up an interface with outside community providers.

We believe that enhancing this workflow and ensuring plan of care summaries are correctly being routed to the community providers will improve patient outcomes, reduce readmissions and create a better patient experience.

4. Please use the space below to describe how the intervention and any selected local quality measures to be addressed by the intervention align with community needs identified throughout the Community and Health Neighborhood Engagement process (including data identified in the hospital's CHNE midpoint and final reports), including but not limited to:
    - How the intervention and any selected local quality measures to be addressed by the intervention were selected based on identified community needs, including how they align with identified significant behavioral and physical health needs and / or service capacity resources and gaps, including related to care transitions and social determinants of health;
    - How the population of focus aligns with identified community needs; and
    - How the proposed intervention will leverage available medical and / or social resources and partners.

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

The CHNE process provides BCH a better understanding of the community needs and evaluate potential gaps in our services locally.

Although the community did not indicate there is a gap in our summary of care records, they did identify further support needed to address chronic disease management, mental health, chronic pain management and substance abuse, wellness and preventative health, including aging of the population and access to care. Ensuring that the PCP receives the information and follow-up instructions post-acute hospitalization, we expect to see better patient outcomes, more efficiency and well-informed physicians so that better evaluations and follow-up can occur. We believe this will have a positive and significant impact on addressing chronic diseases, mental health and substance abuse disorders, improving patient education and will ultimately reduce readmissions resulting in a reduction of Medicaid costs.

We continue to face challenges in our community addressing homelessness, substance abuse and mental illness. Our 2020 Multi-Visit Patient review shows that Alcohol, Drug Abuse or Dependence is in the top 7 DRGs of our multi-visit patients; those insured by Medicaid account for 22% of this population. BCH continues to identify ways in which we can address this population by leveraging current community partnerships, complex care planning with the IDT and more standardized hand-offs across the continuum.

It will be critical to address the needs at the local and community level by strengthening our partnerships with Colorado Community Health Alliance (RAE) and Clinica Family Health Services (FQHC) and ensuring we are working efficiently and collaboratively on this initiative.

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)

Option 2 - Best practice supported by less than RCT evidence

The evidence base intervention selected entails increasing the successful transmission of a summary of care record to a patient's primary care physician (PCP) or other healthcare professional within one business day of discharge from an inpatient facility. A change of this magnitude is possible but does require hospital wide engagement and adoption (1). It can be challenging to navigate multiple electronic systems across clinic providers and community partners making it critical to optimize our Epic system to improve the coordination of care as well as minimize inefficiencies and errors. Williams et al (2012) express "Electronic health

information exchange addresses a critical need in the US health care system to have information follow patients to support patient care. Today little information is shared electronically, leaving doctors without the information they need to provide the best care. With payment reforms providing a strong business driver, the demand for health information exchange is poised to grow (2)." This intervention also allows the PCPs and other professionals to receive crucial information needed for follow-up which will organically lessen the burden on these providers to reach out for relevant information.

References -

1. Dean, S. M., Gilmore-Bykovskyi, A., Buchanan, J., Ehlenfeldt, B., & Kind, A. J. (2016). Design and Hospitalwide Implementation of a Standardized Discharge Summary in an Electronic Health Record. Joint Commission journal on quality and patient safety, 42(12), 555–AP11. https://doi.org/10.1016/S1553-7250(16)30107-6

2. Williams, C., Mostashari, F., Mertz, K., Hogin, E., Atwal, P. (2012) From The Office Of The National Coordinator: The Strategy For Advancing The Exchange Of Health Information. Health Affairs. 31(3). https://doi.org/10.1377/hlthaff.2011.1314

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)

IT Road Map - By relying on our EHR to gather and store crucial data regarding a patient's preferred PCP, we continue to eliminate the silos that exist in the healthcare. Engaging technical approaches makes sharing care coordination information easier and more seamless for patients and staff. The goal of this HTP intervention will also highlight the need to better develop our data sharing and analytics across our community partners and ultimately improve our coordination of care.

Healthcare Workforce - The resources to support the education of health care personnel and the adoption of administrative and regulatory policy that allows health care workers to work at the top of their scope of practice, education, training and competency. BCH has made this a priority undertaking to educate staff on the benefits of use of the EHR and we can continue to optimize EPIC to its greatest capacity. This extends to the entire BCH system to create a shared seamless continuum of care between patients and providers.

Primary Care Payment Reform - The changes that will be a result of HTP initiatives are designed to support primary care providers through the shift of being paid for quantity to quality. BCH is well aligned to also support this measure by encouraging more communication with patients and across the BCH system to engage a true team-based approach to lower healthcare costs.

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)

BCH has experience with this intervention. Since our go-live with Epic, we now can share information with other Epic partners in the community.

Our FQHC receives the CORRHIO PEN report which provides daily information on ED visits and hospital discharges for their patients, so long as we have the correct RAE listed in Epic. Clinica Family Health Services (FQHC) has a transitions of care team that runs the report daily and makes two attempts to outreach patients in order to connect to care. Furthermore, Clinica does have Epic CareLink access and we hope this HTP intervention will further strengthen our ability to utilize Epic CareLink for better sharing of clinical post-acute needs.

BCH Ambulatory Clinic RN Care Managers and Behavioral Health Specialists can identify recently discharged patients from both the ED / Inpatient Unit by utilizing an existing Epic report. The advantage of sharing the same Epic system across the inpatient / outpatient settings is that we can easily follow-up on recommendations and treatment plan to ensure we are addressing any critical treatment recommendations. Additionally, the inpatient staff can send the transfer of care summaries electronically to the PCP clinic via CareLink portal. Enhancing our ability to share these summaries, by electronically identifying the correct PCP clinic with an automatic push of records via our Epic CareLink portal, will be essential in improving outcomes, lessening errors and decreasing readmission rates within the Medicaid population.

We strive to breakdown any barriers to care by working creatively with community partners. We contract with AMR and Lyft Health and solve for transportation issues as they arise. We may also provide local bus passes if that is patient's preferred route of transportation. We are regularly in communication with Clinical Family Health Services and on a weekly basis will discuss our complex, high utilizer patients to ensure follow-up appointments and additional education are provided.

Our RAE is highly engaged when a Medicaid patient is hospitalized and regularly discusses treatment planning and discharge options with the Care Managers. The RAE has experienced and well-trained clinicians that outreach patients post discharge and will assist in the transitions of care and provide additional education / resources as needed.

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)

BCH selected an existing intervention because it is the best approach for meeting the community needs and addressing gaps in coordination of care within our community. We can leverage the work that has been done since our transition to Epic in the Fall of 2019 to better enhance technical capabilities in the future. As an organization we are becoming more efficient and comfortable utilizing Epic and we continue to learn more about its capabilities, such as data sharing and analytics. BCH will make this HTP intervention a priority and will focus on strengthening what has already been created in our Epic system and enhancing this work across other providers and partnerships and improving modes of communication and efficiency resulting in better transitions of care.

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)
Boulder Community Health	PCMP	Yes	BCH Primary Care Clinics will collaborate with BCH Care Managers and Unit Coordinators on delivering timely follow-up appointments and identifying new PCP referrals.
Clinica Family Health Services	FQHC	Yes	Clinica will continue to collaborate with BCH in order to deliver timely primary care follow up by scheduling patients post discharge and providing additional education and resources.
Colorado Community Health Alliance	RAE	Yes	The RAE will continue to support BCH in this follow-up initiative by providing additional resources and education and linking patients to care.
Global Medical Response	Regional EMS	Yes	GMR (AMR) will collaborate with BCH on addressing transportation barriers that inhibit timely PCP follow-up.

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.