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: Readmission Reduction Program

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. CP1 - Readmission for a High Frequency Chronic Condition 30 Day (Adult)

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 30-day readmission rate for high frequency chronic conditions entails building on an established Readmission Reduction Program (RRP). The RRP will complete its work through the established committee structures, Patient Safety and Quality Committee, Readmission Avoidance Steering Committee and Boulder Heart/Boulder Valley

Pulmonology Transitional Care Management Committee. The executive sponsor is the system Chief Medical Officer and report outs will be made regularly to system Senior Executives as well as the Board of Directors. We will engage system leadership and educate current committee members on HTP and rationale for expansion of services to address chronic condition readmission rates in our Medicaid population. Furthermore, the RRP will develop structure for where HTP program metrics and workflows will be managed. To achieve this goal staff will review Medicaid data, from claims and internal system data, to assess for opportunities to decrease readmission rates on chronic conditions. Based on evidence review, we will prioritize conditions with highest readmission rates. BCH will continuously evaluate and capitalize on opportunities to improve care by identifying areas of needed improvement in service provision, patient education and community engagement for care across the continuum. When areas for improvement are identified, appropriate team members will be engaged to begin developing the improvement process; which will develop metrics to monitor improvement ongoing and build program sustainability.

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 to evaluate potential gaps in our services.

Chronic disease management has been identified as an area where the community perceives there are gaps and that we have identified as a core commitment of our health system. Chronic diseases identified include the care of diabetes, coronary artery disease, cerebrovascular disease, cancer care, and preventive care. They account for roughly 50% of health care spending in Boulder County. Behavioral Health (including mental health and substance use disorders) impacts both acute and chronic care and also consistently rises to the top as an area of concern for our community.

BCH choosing to address CP1 – Readmission Rate for a High Frequency Chronic Condition 30 Day, will directly address concerns related to chronic disease management. When these conditions are better managed we would expect to see a reduction in hospitalization and readmission rates. Identifying and proactively engaging patients during an acute hospitalization will assist us in providing better patient education to address social determinants of health and other conditions that inhibit a person's ability to engage in ongoing care, including MH disorders and to engage community partners and providers.

Medicaid patients seen at BCH for these chronic conditions may have a BCH primary care provider, but many will be seen at our FQHCs and other community primary care practices. We will need to build systems and strengthen current relationships to ensure the ongoing care of our population addresses their needs post an acute hospitalization. We will need to build on the work of our RAE to ensure there is ongoing primary care for our Medicaid patients.

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 RTC evidence. The evidence base of research cited below reflects on how BCH's governance structure will be overseeing readmission prevention, reviewing new data and identifying drivers of change, and implementing local teams to address these conditions. While individual factors certainly play a role in patient risk for 30-day hospital readmission, the bigger-picture factors that can influence this are Medicaid payer status and organizational characteristics (3). Our current Transitions of Care approach, based on the Coleman Care Transition and Project Red models (2, 4), has produced positive results in our Medicare population and we would like to prove that can be translated to the Medicaid populations by integrating the research that supports this intervention. Chronic diseases usually do not occur in isolation and are still poorly understood (1). By building on our approach to continue to engage existing committees in utilization review, address social determinants of health and enhancing community engagement and coordination of care, we will assist our Medicaid population in improved management of chronic disease.

Citations:

1. Brunner-La Rocca H-P, Peden CJ, Soong J, Holman PA, Bogdanovskaya M, Barclay L (2020) Reasons for readmission after hospital discharge in patients with chronic diseases—Information from an international dataset. PLoS ONE 15(6): e0233457. https://doi.org/10.1371/journal.pone.0233457

2. Coleman E., Smith J., Frank J., Min SJ., Parry C, Kramer A. (2004) Preparing patients and caregivers to participate in care delivered across settings: the Care Transitions Intervention.

Journal of American Geriatrics Society. 52(11). 1817 – 1825. DOI: 10.1111/j.1532-5415.2004.52504.x

3. Conner, K., Hongdao, M., Marino, V., Boaz, T. (2020) Individual and Organization Factors Associated With Hospital Readmission Rates: Evidence From a U.S. National Sample. Journal of Applied Gerontology, Vol. 39(10) 1153–1158 sagepub.com/journals-permissions DOI: 10.1177/0733464819870983 journals.sagepub.com/home/jag

4. Greenwald, J., Denham, C., Jack, B. (2007) The Hospital Discharge. Journal of Patient Safety. 3 (2). 97-106 doi: 10.1097/01.jps.0000236916.94696.12

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)

The intervention selected aligns with the ongoing statewide initiatives that include, but not limited to, the following:

Affordability Road Map - BCH is a partner on the journey to make healthcare more accessible to Coloradans and will use this intervention to continue to support Innovative Health Care Delivery and Reform Models. By addressing chronic conditions through a preventive care lens, as well as behavioral health and substance use disorders, BCH can provide upstream intervention before an issue exacerbates and results in rehospitalization.

ACC -BCH's goals for the RRP align closely with those of the of the ACC in seeking to improve member health by addressing chronic conditions and, as a result, reducing costs associated with readmission. We will achieve this by engaging all aforementioned systems and service lines as well as by strengthening coordination of services through Team based Care and Health Neighborhoods. This will provide more collaboration across the care continuum and allow participants to have concerns addressed by primary care, or other outpatient setting, to avoid rehospitalization.

SIM - To further build on the efforts to focus on whole-person care, with the goal of avoiding unnecessary rehospitalizations, this intervention will also support the SIM Continuation initiative. By engaging not only the patient, but also their primary care provider or a provider at a BCH affiliated FQHC, medical or behavioral health concerns can be assessed and addressed in an outpatient setting or at a lower level of care. We will also engage the patient and any appropriate caregivers in the initial discharge process to inform and empower them to make the best choice to support their health post-discharge

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 utilizing governance structures to improve performance on patient safety and quality metrics, including readmission prevention. We have not used this intervention to directly impact the readmission rates of Medicaid patients but have had success in the Medicare population. Our prior experience with this framework will enhance the likelihood of success with this important initiative. In addition, our local FQHC has a strong commitment and dedicated program to improve transitions of care for their Medicaid population. Enhancing our collaboration with them should positively impact this measure. Our RAE, CO Community Health Alliance, has experience linking members to primary care, assisting them in care transitions and addressing SDOH. Enhancing our communication and collaboration will also positively impact our population.

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)

This intervention in this population is not already in existence; focusing this approach on the Medicaid population will be a new intervention strategy for BCH.

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)
Clinica Family Health Organization	FQHC	Yes	Active engagement of their population in chronic disease management care transitions

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.