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: RAH1 - Follow up appointment with a clinician made prior to discharge

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. RAH1 - Follow up appointment with a clinician made prior to discharge
2. and notification to the Regional Accountable Entities (RAE)
3. within one business day

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 RAH 1 - Follow up appiontment with a clinician made prior to discharge, entails a connection to primary care provider (PCP) prior to discharge via an initial appointment scheduled as well as a notification sent to the Regional Accountable Entity (RAE) within one business day. We will leverage Epic's capabilities at BCH to capture PCP information and automatic notification to the RAE upon discharge. BCH staff have the ability to pull the PCP information at time of admission and will strive to decrease the number of patients for which this information has not been captured at registration. We will work with BCH leaders and IT analysts on developing education for staff to identify and confirm PCP information then utilize Epic to schedule appointments, confirm follow-up and identify the patient's RAE. Engaging in a multi-step process of identifying PCP information at time of admission and collaborating with the patient on appointment scheduling for recommended follow-up,will reduce the rate of readmissions and improve quality of care. The RAE information is currently listed within our Epic system, we will strive to ensure this is accessible for all staff and that appropriate education how to obtain this information is distributed. The follow-up appointment details will be updated in the AVS section of Epic and easily comprehensible for patients, family and/or caregivers. We believe we are creating the most efficient way to identify and schedule follow-up appointments by utilizing our EHR's capabilities and working closely with our RAEs representatives on timely and appropriate notifications. BCH's goal is to have a fully trained Unit Coordinator staff that can electronically schedule patient's PCP follow-up appointments prior to the discharge. The Case Management Department at BCH will work to collaborate with the patient/family/caregivers when there is not an active PCP listed and will coordinate with our BCH Primary Care Clinics or other community partnerships on scheduling new patient appointments within one week. The best practice to accomplish this work is a discussion with the patient and/or caregiver prior to discharge to set up the appointment. Inclusion of the patient in the identification of date and time of the follow-up appointment supports not only patient centered care but increases the likelihood of adherence to the appointment (1). We believe we are creating the most efficient workflow by utilizing an interdisciplinary team approach to schedule appointments and make new PCP referrals.

BCH's Case Management team will continue to work with the Unit Coordinators on all hospital units to identify patients without PCPs and will meet with patients to discuss options and make referrals. The Unit Coordinators on all hospital units will automatically schedule PCP follow-up appointments within seven days of discharge and will coordinate with Case Management to communicate with patient and identify additional resources needed. We believe this intervention will improve both patient outcomes and patient experience by ensuring integration of care is occurring across the continuum and with local community partners. Reducing unnecessary readmissions is a patient safety goal in the BCH system and will assist with the state goal of reducing Medicaid costs. Working with community partners and utilizing our existing BCH clinics will advance our ability to reduce costs, provide high quality care and promote coordination of care across the continuum. The collaboration with our primary clinics and other local PCPs and community partners will improve our transitions of care, create stronger community partnerships and decrease healthcare disparity.

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 a gap in PCP follow-up appointments was not specifically listed, the community identified 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. Increasing the amount of PCP follow-ups within 7 to 10 days of discharge and breaking down barriers to accessing care, will have high impact on addressing not only chronic diseases, overall wellness and community education, but will lead to ultimately reducing readmissions. If BCH works to address the SDOH, engage with our patients and community partners, strengthen our current relationships and utilize our RAE to ensure patients are accessing their community providers and engaging in care, we will improve our Medicaid population's health outcomes.

We continue to face challenges in our community addressing homelessness, substance abuse and behavioral health. Boulder County is working on creating a robust community partnerships that include representatives from BCH, the Boulder Shelter for the Homeless, Boulder PD, City of Boulder, and Boulder County Jail with the goal of quickly identifying the most complex, high utilizers and addressing the barriers to care such as housing, transportation, and food insecurity. Our complex care management team at BCH will continue to review cases to address some of these Social Determinants of Health and strive to engage the community partners, including the RAE, on breaking down barriers, thus reducing readmission rates at BCH.

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) to ensure 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 support by less than RTC evidence -The scheduling of follow-up appointments prior to discharge is an evidenced based practice and research indicates readmissions rates can fall with pre-arranged follow-up appointments (3).The evidence states that typically 1 in 5 patients suffers an adverse event following hospital discharge (1). Research shows that involving hospitalized patients, and their family members, in post-discharge planning increases attendance rate at follow up appointments (2). Furthermore, by addressing the gaps in systemic structure, ie: electronic health record, we can help to ensure smoother transitions for patients post-hospitalization.

References –

1. Baky, V., Moran, D., Warwick, T., Goerge, A., Williams, T., McWilliams, E., Marine, E. (2018) Obtaining a follow-up appointment before discharge protects against readmission for patients with acute coronary syndrome and heart failure: A quality improvement project. International Journal of Cardiology 257, 12 – 15. https://doi.org/10.1016/j.ijcard.2017.10.036

2. Chang, R., Spahlinger, D., Kim, C. (2012) Re-Engineering the Post-Discharge Process for General Medicine Patients. Adis Data Information 5(1), 27 – 32.

3. Lam, K., Abrams, H., Matelski, J., Okrainec, K. (2018) Factors associated with attendance at primary care appointments after discharge from hospital: a retrospective cohort study. CMAJ Open. 6(4) 587 – 593. DOI:10.9778/cmajo.20180069

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:

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.

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 Inovative Health Care Delivery and Reform Models. By addressing chronic conditions through a preventive and primary care lens, BCH can provide upstream intervention before an issue exacerbates and results in rehospitalization.

Accountable Care Collaboraitve (ACC) - BCH's proposed intervention for the Hospital Transformation Program, RAH1, aligns closely with those of the of the ACC in seeking to improve member health by reducing hospital readmission and associated costs. 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 provde more collaboration across the care continuum and allow participants to have concerns addressed by primary care, or other outpatient setting, to aviod rehospitalization.

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 and initiated a pilot program in early 2019 that included scheduling of appointments for all BCH Primary Care Clinics prior to discharge. Currently, BCH obtains Primary Care Provider (PCP) information directly from patients at registration; this data carries over to each admission encounter. At times, we have identified issues in obtaining the correct PCP information, or other gaps, including workflow disadvantages

and the inability to flag or alert the Case Manager when there is not a PCP listed, prompting a conversation with new PCP referral.

We identified a quick and efficient way to schedule PCP appointments within our own BCH system. When the patient has a PCP outside of our system, it can be more difficult to get these appointments scheduled in a timely manner and requires long hold times on phone other discharge barriers, for example, weekend PCP availability. Our current practice is to schedule all follow-up appointments for BCH Clinics and Clinica Family Health Services. For other outside PCP offices, recommended follow-up documentation is listed in the After Visit Summary in Epic. BCH strives 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 and may also provide local bus passes if that is patient's preferred route of transportation. We engage in regular communication with Clinica Family Health Services to discuss our complex, high utilizer patients thus ensuring 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 employs experienced and well-trained clinicians that outreach patients post discharge and assist in the transitions of care as well as 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. The process currently in place for scheduling appointments will improve by focusing on this HTP intervention to increase efficiency and IT support. This process is an evidenced based practice and will ultimately result in the reduction of readmissions and improved quality care across the continuum. Our anticipated ability to pull attributed PCP at the time of registration with the ability to confirm the RAE will ultimately lower costs by improving coordination and easing transitions of care across the continuum.

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.