CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

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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: Behavioral Health Care Coordination

2. Please use the table below to identify which statewide and selected local quality measures (from the hospital's response to Question 6 in the Hospital Application) the hospital will address through this intervention. As a reminder, each of the statewide and selected local quality measures must be identified for at least one intervention. As such, if this is the only intervention addressing a given Focus Area, all statewide quality measures and all selected local quality measures for that Focus Area must be included in this response. This response should align with the intervention-specific list included in the response to Question 7 in the Hospital Application.

Please note, hospitals are also required to complete the Intervention Proposal below for statewide priorities identified in Question 6 of the HTP Hospital Application.

Please use the unique identification code from the Performance Measures List (which is available on the HTP website) to identify your selected measures. For example, the measure "30 Day All Cause Risk Adjusted Hospital Readmission" should be listed as SW-RAH1.

Response (Please format the response as a numbered list)

1. SW-BH1: Behavioral Health Collaborative Discharge Planning Process & Notification to the RAE

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)

To address quality measure SW BH1 - the behavioral health collaborative discharge planning process and notification to the Regional Accountable Entity (RAE), Boulder Community Health (BCH) will implement an intervention identifying adult clients, 18 years or older, who discharge from the hospital or emergency department with a principal or secondary diagnosis of mental

illness or substance use disorder. The eligible clients included within the intervention must be able to give consent or meet criteria to be individuals whom state and federal statutes allow notification without consent. The BCH informed consent documentation and procedure will follow the FDA's recommendations for informed consent to include: "Informed consent must include a process that facilitates the subject's comprehension of the information and allows an adequate opportunity for the subject to ask questions and consider whether or not to participate (3)." BCH's planned invention will engage applicable community stakeholders and the RAE to create collaborative discharge planning processes that deliberately pair available resources to appropriate, consenting clients. BCH will utilize EPIC EHR After Visit Summary (AVS) to transmit admission, discharge, and transfer information to the RAEs. Consistent with continuous quality improvement principles, ongoing intervention modifications may need to occur to impact other HTP outcomes such as readmission rates or accommodate our staff, community, and patients' evolving needs.

This intervention will advance the Hospital Transformation Program's goals by focusing on care integration to improve patient outcomes and patient experience. Through this intervention and the others proposed through the HTP framework, BCH will reduce unnecessary costs and promote value-based care. We believe the EPIC-based AVS will provide a model for communication and collaboration within the community and state.

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 allowed BCH an opportunity to review and identify the primary areas of need for care coordination and access. Based on the CHNE resources, the organizational and community stakeholders identified the appropriate intervention to address collaborative, complex discharge planning and care continuity. The stakeholders identified a lack of care coordination between levels of care and community organizations, and, compounding factors, a limited amount of mental health and substance use disorder (SUD) residential and outpatient substance use treatment services. When clients experience a combination of MH, SUD, and other medical issues and disabilities, the availability of resources shrinks exponentially.

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. BCH will continue to review cases and collaborate with our community partners to address some of these

Social Determinants of Health, including the RAE, on breaking down barriers and providing these patients with referral and connection to the appropriate levels of care.

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. BCH is proposing an evidence-based practice to promote the sustained wellness of BCH community members by reducing the risk of suicide, self-harm, or relapse after discharge form the BCH emergency department and inpatient psychiatric unit. Studies show that nearly twenty percent of US Medicare beneficiaries were readmitted 30 days after discharge, resulting in an annual cost of $17 billion (4). The common barriers for safe discharge include legal and financial issues, behavior management, capacity issues for differing levels of care, and interhospital/agency transfers (1). The identification of clients at risk, by a mental health professional, partnered with a targeted needs assessment, link to area organizations for support services, and universal communication transfer document are a patient-centered process designed to proactively identify and assess a patient's return to baseline and safe discharge. Continuity of care and transition planning notably reduced recurrent homelessness and psychiatric rehospitalization (2). Furthermore, transitional interventions, including pre and post-discharge discharge psychoeducation, structured needs assessment, medication reconciliation/education, transitional care document, and case management/service navigation, added to discharge planning reduced inpatient psychiatric admissions by 13.6-37% (5).

References -

1. MacKenzie, T., Kukolija, T., House, R., Loehr, H., Hirsch, J., Boyle, K., Sabel, A., & Mehler, P. (2012). A discharge panel at Denver Health, focused on complex patients, may have influenced decline in length-of-stay. Health Affairs 31(8), 1786-1795.

2. Tomita, A., Herman, A. (2015). The role of critical time intervention on the experience of continuity of care among persons of severe mental illness after hospital discharge. Journal of Nervous and Mental Disease, 203(1), 65-70.

3. U.S. Food and Drug Administration (FDA). Informed Consent Guidance Document. Retrieved from: https://www.fda.gov/regulatory-information/search-fda-guidance-documents/use-electronic-informed-consent-clinical-investigations-questions-and-answers

4. Viggiano, T., Pincus, H., & Crystal, S. (2012). Care transition interventions in mental health. Current Opinions in Psychiatry, 25, 551-558.

5. Vigod, S., Kurdyak, P., Dennis, C., Leszcz, T., Taylor, V., Blumberger, D., & Seitz, D. (2013). Transitional interventions to reduce early psychiatric readmissions in adults: Systematic review. The British Journal of Psychiatry, 202, 180-194, DOI: 10:1192/bjp.bp.112.115030

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:

Behavioral Health Task Force - BCH will use the proposed intervention to identify systemic gaps to increase access to services for vulnerable populations. Through notification to the RAE of discharge from a behavioral health unit, they can be involved in all steps of the process of supporting both physical and mental health.

IT Road Map - By relying on our EHR to gather and store crucial data regarding consent and protected patient information, we continue to eliminate the silos that exist in the healthcare. Engaging technical approaches makes sharing crucial care coordination information easier and more seamless for both patients and staff.

HQIP - Zero Suicide measure????

Accountable Care Collaborative (ACC) - BCH's proposed intervention for the Hospital Transformation Program, SW BH1, aligns closely with those of the of the ACC in seeking to improve member health by reducing costs and strengthen coordination of services. 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 ongoing concerns addressed at the appropriate level of care.

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)

The research shows that Medicaid enrollees are a more vulnerable population that have difficulty navgating the different systems. The expereince of BCH and many of our community partners is that these patients face extreme challnages when trying to connect with follow up behavioral health care. By engaging the RAE and ensuring ongoing support in the outpatient setting, we can assist in breaking down barriers to care for the most at-risk patients 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)

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)
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

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.