



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: Stroke Discharge on Statin
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. RAH 4 - Percentage of patients with ischemic stroke who are discharged on statin medication

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)

Boulder Community Health (BCH) selected RAH4, statin on discharge to ensure we continue to provide the highest quality of care to our community as a Joint Commission certified Primary Stroke Center. Hyperlipidemia is a major risk factor for stroke. Studies have proven that statin medications are effective in reducing the risk of recurrent ischemic strokes. In addition, these



medications have remained the first line agents to decrease cholesterol, reduce recurrence of stroke and risk of cardiovascular disease. Conversely, research shows that other means of lowering lipids has not been as effective in reducing the risk of stroke and cardiovascular disease. The 2019 American Heart Association (AHA) refers to the 2014 AHA guidelines as well as the 2018 guideline on Management of Blood Cholesterol. Under these guidelines, the goal of therapy for secondary prevention is an LDL <70mg/dL.

As a Primary Stroke Center we've continued to monitor this measure within our performance improvement plan. We have multiple teams dedicated to tracking BCH's performance and outcomes for our stroke patients. The Stroke Core Team is made up of our RN Stroke Program Coordinator and the Stroke Program Medical Director. This team is responsible for identifying misses, analyzing the data, presenting the data and case reviews at the two committees, providing direct feedback to the ordering physicians and ensuring performance improvement opportunities are identified and carried out. Our RN Stroke Program Coordinator is our stroke expert, managing the Joint Commission Primary Certification as well as meeting AHA Get With The Guidelines. The background required is NIHSS certified, neurology and critical care experience with preferred stroke certification. The Stroke Program Medical Director is a neurologist with extensive stroke management experience. This core team attends the annual National Stroke Conference and monthly front range stroke committee. Data is reviewed along with individual cases that fallout of the percent positive and the teams identify opportunities for improvement. Thus far the following actions have taken place to ensure compliance with this standard:

- a. Standardized Stroke order sets including statin therapy
- b. Stroke Coordinator performs real-time audits during the weekdays to ensure compliance
- c. Review of patient charts to confirm patient education on post-stroke statin therapy
- d. Review of population qualifying for intensive statin therapy and adherence to the AHA best practice guidelines
- e. The Stroke Quality Committee meets to review data compliance monthly
- f. The Stroke Program committee meets to review data and compliance quarterly
- g. Misses or those cases found in noncompliance are reviewed as a case study and feedback is provided to the ordering physician

Assessments are performed in person and handoff is given at bedside. Physicians communicate via phone (ED, Neurologist and Hospital Medicine) and nursing communicates via bedside handoff and phone to ensure safe communication handoff. Once patient is admitted, we use bedside or face to face communication for shift to shift report and transfers. There's also daily interdisciplinary team rounds between physician, nurse, therapy, pharmacy and case management. Patients are given 1:1 in person education throughout their stay as well as at time of discharge. We also provide written materials on medications including statin therapy. In the event the patient transfers to Swedish BCH provides a physician to physician telephone report or via telehealth robot and the nursing staff performs telephone report.



Core Team members round and meet daily to weekly as needed. The Stroke Program Committee meets quarterly and the Stroke Quality Committee convenes monthly. These meetings typically occur in person and via conference line for those who cannot attend physically. Due to pandemic infection prevention standards we've been meeting via the virtual platform WebEx. The Core Team follows up with care providers in person and via email.

In terms of direct intervention, staff and physicians access orders via our electronic health record, Epic, and print any pertinent documents for patient education. BCH also provides information on our website and internal employee portal. Patients are provided a stroke booklet which covers the risks of primary and secondary strokes. This literature also includes information about statin medication post-stroke. The Get With The Guidelines and Joint Commission measures of statin ordered at discharge are collected monthly.

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)

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 patient receives these medications and follow-up instructions post-hospitalization, we expect to see better patient outcomes and more efficiency in aftercare. We believe this will have a positive and significant impact on addressing both acute and chronic illnesses, improving patient education and will ultimately reduce readmissions resulting in a reduction of Medicaid costs.

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 resources guiding BCH's practice with this patient population include many guidelines from the American Heart Association.

1. Grundy, S., Stone, N., Bailey, A., Beam, C., Birtcher, K., Blumenthal, R., Braun, L., de Ferranti, S., Faiella-Tommasino, J., Forman, D., Goldberg, R., Heidenreich, P., Hlatky, M., Jones, D., Lloyd-Jones, D., Lopez-Pajares, N., Ndumele, C., Orringer, C., Peralta, C., Saseen, J., Smith Jr, S., Sperling, L., Virani, S., Yeboah, J. (2018). AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APHA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. American Heart Association Journals. Circulation 130(25). 1082 - 1143 doi.org/10.1161/CIR.0000000000000625
2. Kernan, W., Ovbiagele, B., Black, H., Bravata, D., Chimowitz, M., Ezekowitz, M., Fang, M., Fisher, M., Furie, K., Heck, D., Johnston, SC., Kasner, S., Kittner, S., Mitchell, P., Rich, M., Richardson, D., Schwamm, L., Wilson, J., (2014). Guidelines for the Prevention of Stroke in Patients With Stroke and Transient Ischemic Attack: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association. American Heart Association Journals. Stroke. 45 (7). 2160 - 2236. doi.org/10.1161/STR.0000000000000024
3. Powers, W., Rabinstein, A., Ackerson, T., Adeoye, O., Bambakidis, N., Becker, K., Biller, J., Brown, M., Demaerschalk, B., Hoh, B., Jauch, E., Kidwell, C., Leslie-Mazwi, T., Ovbiagele, B., Scott, P., Sheth, K., Southerland, A., Summers, D., Tirschwell, D. (2019). Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association. American Heart Association Journals. Stroke. 50 (12). 344 - 418. doi.org/10.1161/STR.0000000000000211

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 identify 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)

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 stroke care through a preventive care lens, BCH can provide upstream intervention before another stroke occurs and results in rehospitalization.

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 and uses of statin medications. This extends to the entire BCH system to create a shared understanding best practice as well as a seamless continuum of care between providers.

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 shown high compliance and rates of success with discharging patients with stroke on statin medications; maintaining 90% or greater for all stroke discharges. In addition to our internal experts, we also partner with Blue Sky Neurology at Swedish Hospital, which is a Comprehensive Stroke Center. BCH contracts with Swedish and Blue primarily for their telehealth stroke services and uses many of Swedish's best practices in stroke care. It is critical that we



align in our treatment protocols to ensure safe handoff and care coordination. The team communication begins between EMS (ground and air) as a telephone call. Once this occurs, BCH uses the overhead paging system to call ‘stroke alert’ and then calls Swedish Blue Sky Neurology via telehealth robot and phone call.

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 documented best practice to support critical aftercare of ischemic stroke patients.

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)
Blue Sky Neurologists			
Swedish Medical Center			



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)

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](#).

