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: HTP Hospital Index Committee

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-COE1 - Hospital Index

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 SW-COE1 Hospital Index intervention includes establishing an HTP Hospital Index Committee. This committee would address the cost of care for the Medicaid population at BCH. This would consist of establishing the appropriate multidisciplinary committee members.

The initial stage of the intervention would consist of establishing a committee charter. This committee would be supported by the Chief Medical Officer and report to the Quality and Patient Safety Council. As a new committee, this would include selection of the appropriate committee members. The second portion would consist of establishing data metrics and analytics to best identify care variations and improve efficiencies specific to this population. The analytics would support identifying the top procedures. This committee would focus on the top procedures or diagnoses to identify opportunities for improvement to establish quality improvement initiatives. These initiatives would take place by utilizing the PDSA improvement methodology. This intervention will support the goals of the HTP by working to reduce the total cost of care to the specific identified areas. This intervention should support increasing efficiencies in the delivery of care and allow for improved collaboration with our community partners including the transparency of data and improvement efforts.

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 at BCH supports identifying the needs of the community. Although addressing cost of care was not directly identified as a community needs, the improvement of chronic disease management and traumatic injury, preventive care and wellness impact avoidable care. Some of the Hospital Index procedures cost impact could be improved with the improvement of chronic disease management prevention and wellness. In some of the communities BCH serves, there exist higher rates of poverty with residents being unemployed or underemployed. This places many of our Medicaid patients at high risk of financial hardship secondary to costs associated with healthcare. To address potentially avoidable healthcare costs, there needs to be consideration for the Social Determinants of Health (SDOH). Based on findings from our most recent Community Needs Assessment, those struggling with behavioral health and/or substance use disorders continue to be Boulder Community Hospitals highest utilizers of care. Many of our behavioral health patients also have additional comorbid conditions that reflect poor access to care, neglect related to poor insight and lack of community resources to assist the behavioral health patient. When patients are food insecure, lack safe and affordable housing, or face barriers to transportation for non-emergency medical appointments and routine or preventive healthcare, as well as the costs associated with it, healthcare becomes less of a priority. Quite simply, when safety is at risk, health is at risk.

Putting focus SW-COE1 - Hospital Index, will allow BCH to consider the cost of care through a more wholistic lens. Our Patient Centered Medical Home model which focuses on relationship-based care with an orientation toward the whole person, provides a framework for better

coordination of patient care across the broader health care system including community supports and services, to improve outcomes, support a positive patient experience and control costs. By engaging with community partners that address SDOH we can provide connection and warm hand-offs for patients to obtain the necessary support to meet their needs and achieve improved health outcomes.

5. Please identify the evidence base (academic, professional or otherwise) related to this intervention's use among the target population by selecting one of the following options:

   (1) Randomized Control Trial (RCT) level evidence
   (2) Best practice supported by less than RCT evidence
   (3) Emerging practice
   (4) No evidence

If you selected option 1, 2 or 3 above, please use the space below to summarize the evidence base (academic, professional or otherwise) related to this intervention's use among the target population. The response should address the intervention's ability to impact the selected local and statewide quality measures identified in Question 6 in the Hospital Application. Please submit the response in narrative form and provide links to any reference documentation (data, citations, etc.).

If you selected option 4 indicating that there is no known evidence base, please explain why this intervention is being proposed regardless.

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

Option 2 - Best practice supported by less than RCT evidence - The evidence supports a range of measures to guide efforts on reducing avoidable costs. The Robert Wood Johnson Foundation encourages the use of data to reduce health disparities to improve quality and therefore costs (3). Berger et al (2020) suggest hospitals incorporating patient feedback; patients play multiple roles in the healthcare system as contributors, targets and reformers. This study went on to further report that patients are more willing to share their feedback and struggles with the healthcare system if they are involved in the care process and if the feedback process if confidential, reliable and transparent (1). The research also highlights the importance of the SDOH playing a role in avoidable costs for both patients and hospitals. Time and time again, it has been proven that the majority of healthcare spending goes to the highest utilizers. Systems can drive down these costs by linking patients with the appropriate community resources (4). It would make sense to incorporate patient feedback to identify where patients are experiencing health inequity and apply a proactive intervention. Gao et al (2014) prove this point further by suggesting this very practice in the primary care setting to help predict potentially avoidable hospitalizations (2).

References -

1. Berger, S., Saut, AM., Berssaneti, FT. (2020) Using patient feedback to drive quality improvement in hospitals: a qualitative study. BMJ Open. 10. doi:10.1136/ bmjopen-2020-037641

2. Gao, J., Moran, E., Li, Y., & Almenoff, P. (2014). Predicting Potentially Avoidable Hospitalizations. Medical Care, 52(2), 164-171. Retrieved March 24, 2021, from http://www.jstor.org/stable/24465865

3. Robert Wood Johnson Foundation (2014) Using Data to Reduce Disparities and Improve Quality: A Guide for Health Care Organizations. https://www.rwjf.org/en/library/research/2014/04/using-data-to-reduce-disparities-and-improve-quality--a-guide-fo.html

4. Sterling, S., Chi, F., Weisner, C., Grant, R., Pruzansky, A., Bui, S., Madvig, P., Pearl, R. (2018). Association of behavioral health factors and social determinants of health with high and persistently high healthcare costs. Preventive Medicine Reports. 11. 154 – 159 https://doi.org/10.1016/j.pmedr.2018.06.017.

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)

Behavioral Health Task Force – BCH's mission is to provide our community with the highest value healthcare in an innovative, patient-centric environment. Our vision is partnering to create and care for the healthiest community in the nation. Aligning with the HTP allows us to continue this very work while maintaining focus on both physical and behavioral health. The emphasis on community partnership truly allows treatment to occur in every aspect of a patient's life. As the hospital, we are one entity, but relying on our partners to fill in gaps when and where appropriate, reduces barriers and provides patients with the highest level of service to meet their needs.

Affordability Road Map – To achieve increased access to health care and insurance coverage while offering these services at a lower cost, the HTP framework supports an organic shift from "fee-for-service" model to value-based care with the intent to lower hospital prices in the long run. In collaboration with other HTP measures BCH will be focusing on, this intervention aligns with the Affordability Road Map by engaging mutitple systems, including both BCH inpatient and Primary Care, to explore and address patient needs before a potential hospitalization therefore providing more targeted and cost-efficient care.

Accountable Care Collaborative (ACC) - BCH is constantly engaging in utilization review to find out where gaps exist and how we can improve service provision and cost savings for our patients. By addressing chronic conditions through a preventive care lens, as well as behavioral health and substance use disorders, we can apply an upstream approach to improve member health and, ultimately, reduce costs for all involved.

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

7. Please use the space below to explain any experience the hospital or any affiliated community partners have had with this type of intervention or target population and how that experience will support the success of the intervention.

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

Currently our only expereince comes from the most recent Community Needs Assessment. Until baseline information can be established and reviewed, we are unable to share any experience related to this intervention.

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 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)
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.

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.