CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

1570 Grant Street
Denver, CO 80203

DRAFT

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: Severity Adjusted LOS

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-PH1: Severity Adjusted LOS

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)
Length of stay management is critical in hospital operations due to the direct connection to patient care. Studies show a clear correlation in patient days with increased likelihood of hospital acquired infections, medication side effects, and decreased quality of patient care. Furthermore,

length of stay is impacted by a multitude of factors including complex discharge barriers, lack of post-acute care treatment options, medical comorbidities, social and economic disparities.

Care Coordination is an essential, proactive approach for appropriately moving patients along the continuum of care and providing continuity among all the services being delivered to the patient both in and beyond the inpatient setting of a hospital. The goals of care coordination include proactively managing length of stay, emphasize patient-centered care and patient choice, ensure evidence-based care and ensure appropriate level of care placement.

Care coordination ensures compliance with the CMS Conditions of Participation (42 CFR 482.43) which highlights the importance of early identification of patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning. Proactive discharge planning helps with the identification of our high-risk patients, assessment of needs and appropriately removing barriers to discharge. Care coordination and proactive discharge planning also improves patient outcomes and decreases readmissions and length of stay.

Utilizing this philosophy, Rose Medical Center plans to implement an interdisciplinary team (IDT) rounding model using the NATE (Next Gen Analytics for Treatment and Efficiency) Tempo Tool, utilizing TREX (Total Readmission Expert) for all admissions, and increasing our collaboration with our RAE partners for Medicaid recipients that are in need of services, support, and resources post hospitalization.

Rose Medical Center has also been selected to participate in the bundled payment initiatives (BPCI-A). As an added benefit from the bundled payments model (which only focuses on Medicare recipients) HCA developed a Plus Care Network which consists of high quality post acute care providers. It is anticipated the Plus Care Network will positively impact our Medicaid recipients in need of post acute skilled services. Plus Care Network providers have been thoroughly vetted to ensure they are providing quality care for our patients and have entered into contractual agreements with HCA to ensure they continue developing strong working relationships with case management (which includes response time), reducing readmissions, and accepting a variety of patients with diverse needs, including our most vulnerable population: Medicaid recipients.

The interventions described above will be implemented for all inpatients regardless of payer source admitted to Rose Medical Center. In order to improve patient outcomes for our most vulnerable and underrepresented groups, our focus will be on inpatient adults (over the age of 18) who have Medicaid as their primary insurance provider.

The proposed intervention aligns with several HTP objectives. One, it can significantly impact and improve patient outcomes by reducing hospital acquired infections and medication side effects. Second, the proposed intervention may improve patient experience through proactive discharge planning and seamless progression through the continuum of care. Third, reduction in severity adjusted length of stay may lead to lower costs through effective care coordination and timely transition from the inpatient status to the next apropriate level of care, whether that is home or a post acute care facility or agency. Fourth, the proposed intervention will strenghten the partnership and collaboration RMC has within it's hospital system (between interdisciplinary members) and outside of the hospital system with it's post acute care partners.

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)
Based on the CHNE (community health and neighborhood engagement) process it was found that:

Rose Medical Center serves a population of high-risk needs patients who are without primary care. This results in poor health management and enhanced risk of chronic underlying disease processes going untreated over periods of time.

These high-risk patients drive a higher length of stay due to higher acuity for management of ongoing medical conditions. Compared to the Denver metro region, Rose's service area population suffers from higher rates of childhood obesity (16.5 percent) and adult obesity (34.2 percent). Relatedly, the population experiences more hospitalizations related to stroke, heart disease, acute myocardial infarctions, and congestive heart failure than the Denver metro population.

In the Rose service area, 6.4 percent of residents were unable to find transportation to their doctor's office or the office was too far away. This rate increases to 8.6 percent in Denver County and decreases to 3.7 percent in Arapahoe County.

This population may also experience food and housing insecurity due to financial and income disparity.

The population would benefit from increased navigation of services, increased community resources and management of both social/behavioral and medical needs.

Evidence shows that decreasing over-utilization by high utilizers is a multi-faceted approach which includes addressing social determinants of health.

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)
Best Practice supported by less than RCT evidence:

In regards to length of stay management, literature suggests that effective case management programs lead to a reduction in length of stay by applying elements such as proactive discharge planning that begins upon admission, standard workflows and documentation, consistent multidisciplinary collaboration and robust analytic tools.

The Institute of Healthcare Improvement emphasizes the benefit and necessity of Multidisciplinary Team Rounds and further describes IDT (interdisciplinary team) rounding as the routine meeting of health care members for the purpose of discussing and planning how best to meet the needs of the patient and family through clinically appropriate services and efficient resource use in order to maximize clinical outcomes and patient transition. The transformational focus includes barrier identification which helps to ensure that the patient is getting effective, efficient and coordinated care to increase communication, patient satisfaction and manage hospital length of stay appropriately.

The Joint commission believes that lack of adequate communication leads to ineffective care transitions from the hospital to post-acute care or home settings. It is critical for the care of our patients to be coordinated to ensure assessment, planning and referrals for safe discharges from the hospital. Ineffective care transition processes lead to adverse outcomes for patients, including medication errors, clinical progression of illness, lack of post-discharge follow up and avoidable emergency department visits. It can also lead to inappropriate use of resources and financial penalties through reduction in reimbursement from the Centers for Medicare & Medicaid Services (CMS) and other insurers.

The NATE (Next Gen Analytics for Treatment and Efficiency) Tempo Tool, designed by Health One, is designed to assist hospitals in improving patient throughput, identifying discharge barriers and improving clinical efficiency and discharge planning. The tool auto-populates key information from the hospitals electronic documentation system and has predictive modeling capabilities. This tool allows for those involved in a patient's care plan to update information in this tracking system as a way to communicate to all key stakeholders providing patient care. NATE tempo was piloted in 2014 and has document success surrounding decreased readmission rates, reduced CAUTI and CLABSI incidents, decreased length of stay, improved management of adherence with sepsis bundles and improved HCAHPS scores.

CITATIONS:

42 CFR § 482.43 - Condition of participation: Discharge planning. Retrieved from https://www.law.cornell.edu/cfr/text/42/482.43

Agency for Healthcare Research and Quality https://ahrq.gov/patient-safety/patients-families/index.html Engaging Patients and Families in their Health Care.

Analysis of Length of Hospital Stay using eletronic health records: A statistical and data mining approach. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5898738/#:~:text=Background,with%20more%20efficient%20bed%20management

Care Management and Reduced Length of Stay: How Leaders Can Connect the Dots. Retrieved from https://www.hfma.org/topics/financial-sustainability/article/care-management-and-reduced-los--how-hospital-leaders-can-connec.html

Institute of Healthcare Improvement. Retrieved from http://www.ihi.org/resources/pages/tools/howtoguidemultidisciplinaryrounds.aspx

Society of Hospital Medicine. Retrieved from https://www.hospitalmedicine.org/clinical-topics/care-transitions/ Advancing Successful Care Transitions to Improve Outcomes

Tempo: Together Everyone Improves Patient Outcomes. St Vincent Hospital.Retrieved from http://www.hpoe.org/MHA_Case_Studies/TEMPOTogetherEveryoneImprovesPatientOutcomes_MHA.pdf

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)
Two goals for the accountable care collaborative is to combine the management of physical and behavioral health under one accountable entity and to strenghten the coordination of services among service providers for Medicaid recipients. Under the ACC, RAE's (regional accountable entities) were contracted out, which Rose Medical Center currently works alongside, and will continue to work alongside for the HTP interventions described above. Strenghtening our coordination of services together will assist in the efforts of reducing avoidable hospitalizations, reducing length of stay and improving overall patient outcomes. The collaboration with our RAE's will also ensure a safe discharge handoff and continuation of much needed services for underserved members of our community.

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)
Rose Medical Center collaborates with the Colorado Access (COA) Care Management Team for our inpatients with lengths of stay above 1 day. The COA Care Management Team receives proactive referrals for coordination on patients that may benefit from additional resources. Additionally, COA Care Management Team receives at least weekly notifications from the Rose Case Management Department to screen and follow patients from the assigned COA RAE. The COA Care Management Team also collaborates for post-acute care services, for follow up PCP visits, and assists patients to ensure they have access to necessary medications and treatments.

Colorado Access (RMC's RAE) receives CORHIO ADT feeds as well as periodic referrals from hospitals. This information allows COA to risk stratify and target interventions for those members who have complex medical issues. The COA Care Management Team, upon referral, provides members transitioning from hospital settings to lower levels of care with appropriate transitions of care intervention, including, but not limited to:

A. Collaboration with hospital staff to uphold timely and member-focused discharge planning;

B. Development of member-driven care plans that incorporate current member status and needs, interdisciplinary team input, and historical clinical information;

C. Submission of member referrals that support ease of access to services and remain consistent with identified member needs;

D. Care coordination activities designed to ensure sustained member access to care and reduce risk for future hospitalization;

E. Exchange of member information, clinical records, care plan goals, and care coordination activities to promote interdisciplinary service delivery;

F. Follow-up with member, provider, and hospital team members to ensure follow through with treatment activities and member success

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)
The Rose Medical Center Case Management Department has a solid care coordination model. The case management team is comprised of social workers and nurse case managers. The case management team completes biopsychosocial assessments on inpatients to assess for discharge needs, resource needs, social support and coordination of services.

Rose Medical Center already incorporates interdisciplinary team (IDT) rounding to discuss goals of care for the day, barriers to discharge and next steps. The goal for our intervention is to make our IDT rounds more robust by utilizing NATE (Next-gen Analytics for Treatment & Efficiency) Tempo software which allows disciplines to come together and efficiently complete their multidisciplinary rounds and assist in patient throughput, decreasing discharge barriers and improving clinical efficiency.

HCA has created Total Readmission Expert (TREX), a data driven tool to predict a patient's risk for readmission within 30 days. This tool utilizes data from 11 sources including: length of stay, chief complaint code, admission type (inpatients only), emergency admission, attending and admitting physician specialty, procedure code and severity, patient height, weight and BMI, pt gender and age, previous visits in any HCA facility, previous ED visits in any HCA facility. This risk stratification tool populates the case management worklist of patients automatically for all patients. Rose case managers will continue utilizing this tool for all patients.

Rose Medical Center plans to continue to coordinate care for our patients, especially those identified as high risk. We will continue incorporating patient and family education into our discharge processes. Rose leadership will also continue holding extended length of stay meetings with key leaders to remove barriers from complex cases for our most at-risk patients.

Additionally, Rose Medical Center case managers maintain excellent working relationships with providers of HHC, SNF, LTAC and IRF. There is sharing of patient information as well as communication about best practices. The goal through the development of the Plus Care Network is to strenghten these relationships with our post acute care providers and to provide more efficient, quality care to our most vulnerable patients that previously were overlooked by community agencies/facilities.

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)

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.