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: Follow up appointment with a clinician made prior to discharge and notification to the Regional Accountable Entities (RAE) with one business day

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

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

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

Response (Please format the response as a numbered list)

1. RAH1

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)

Multiple studies exist which show a link between primary physician supply and better population health. It stands to reason that having adequate access to primary care, especially in the post-hospital discharge setting would further positive health care outcomes by assisting patients in

understanding and following a plan of care. Many studies working to address the issue of hospital re-admission have found that primary care follow up after hospital discharge is an important component of reducing re-admissions. This intervention seeks to insure that all Medicaid patients have an appointment with a primary care provider within 30 days of hospital discharge and that the RAE is aware of this information for out-patient follow up.

We will continue to utilize support from the RAE to identify and arrange primary care appointments for patients within the Colorado Access RAE catchment area. For patients assigned to other RAEs, hospital case management will seek to make follow up appointments and, through COHRIO, communicate this scheduling back to the appropriate RAE.

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)

Emergency department mis-utilization could be addressed by insuring that Medicaid patients have a primary care home and therefore can receive treatment there as medically indicated. Also, linkage with a primary care provider is likely to identify issues for treatment before they become emergent.

The elderly Medicaid population can be assisted to navigate the health care system by having primary care follow-up arranged and by having a contact on an out-patient basis at their primary care office.

Our Medicaid population will benefit from connection with primary care for specialty referral, prescription refills, completion of home care and durable medical equipment (DME) paperwork, as well as routine and urgent 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)

Best Practice: Access to primary care is significantly associated with lower all-cause mortality1 and states with higher primary care to population ratios evidence better health outcomes along multiple measures.2-3 Perhaps not surprisingly, having a primary care provider is significantly associated with patients' being up to date on preventative services such as screening, immunization and habit-counseling services.4 Additionally, access to primary care has been associated with lower health care costs. 5-6 Follow-up with primary care in the post-hospital setting is known to reduce readmissions (and therefore cost)7-9 in disease specific populations. MIske9 found that patients were ten times as likely to re-admit to the hospital if they did not have a primary care follow-up. Among Medicare beneficiaries requiring readmission within 30 days of discharge, 50 percent had not seen a clinician for a follow up visit.10 In addition to lower mortality, lower cost, and reduction in re-hospitalizations (utilization of the health care system), primary care visits contribute to increased outcomes as a result of access to care and relationship to a consistent provider.

CITATIONS:

1. Shi, L., Macinko, J., Starfield, B., Wulu, J., Regan, J., Politzer, R. The Relationship Between Primary Care, Income Inequality, and Mortality in the United States, 1980-1995. Journal of the American Board of Family Practice. 2003a; 16:412-22.

2. Shi, L. The Relationship Between Primary Care and Life Chances. Journal of Health Care for the Poor and Underserved. 1992; 3:321-35.

3. Shi, L. Primary Care, Specialty Care, and Life Chances. International Journal of Health Services. 1994; 24:431-58.

4. Flocke, S.A., Stange, K.C., Zyzanski, K.J. The Association of Attributes of Primary Care with the Delivery of Preventive Services. Medical Care. 1998; 36:AS21-30.

5. Franks, P., Fiscella, K., Primary Care Physicians and Specialists as Personal Physicians. Health Care Expenditures and Mortality Experience. Journal of Family Practice. 1998; 47:105-9.

6. Mark, D.H., Gottlieb, M.S., Zellner, B.B., Chetty, V.K., Midtling, J.E. Medicare Costs in Urban Areas and the Supply of Primary Care Physicians. Journal of Family Practice. 1996; 43:33-9.

7. Wiest, D., Yang, Q., Wilson, C., Dravid, N. Outcomes of a Citywide Campaign to Reduce Medicaid Hospital Readmissions with Connection to Primary Care within 7 Days of Hospital Discharge. JAMA Network Open. 2019; 2(1):e187369. Doi:10.1001/jamanetworkopen.2018.7369.

8. Hernandez, A.F., Grenier, M.A., Fonarow, G.C., et al. Relationship between early physician follow-up and 30-day readmission among Medicare beneficiaries hospitalized for heart failure. JAMA. 2010; 303:1716.

9. Misky, G.J., Wald, H.L., Coleman, E.A. Post-hospitalization transitions: Examining the effects of timing of primary care provider follow-up. Journal of Hospital Medicine. 2010; 5:392.

10. Jencks, S.F., Williams, M.V., Coleman, E.A. Rehospitalizations among patients in the Medicare fee-for-service program. New England Journal of Medicine. 2009; 360:1418.

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: Colorado Access (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)

Collaboration between the hospital and Colorado Access to identify Medicaid patients without a primary care provider which leads to lower mortality, lower cost, and reduction in re-

hospitalizations (utilization of the health care system). Primary care visits contribute to increased outcomes as a result of access to care and relationship to a consistent provider.

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)

Sky Ridge has worked collaboratively with the RAE (Colorado Access) in past to identify Medicaid patients without a primary care provider. The work of the Colorado Access hospital liaison has been crucial in arranging follow up for these patients. Our intent would be to continue this partnership and seek to develop it further for more patients as we develop a means for documentation of the appointments made and communication back to the RAE from hospital case management in those cases where the Colorado Access liaison is not available.

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)

As detailed above, Sky Ridge has been working with the RAE liaison to identify Medicaid patients without a primary care provider. Per our Midpoint Report, Sky Ridge service area has 61.9 primary care physicians per 100,000 residents — lower than the metro Denver rate of 83.3 primary care physicians. The service area also has a lower Nurse Practitioner and Physician Assistant ratio at 146 providers per 100,000 residents, compared to the Denver metro rate of 164 .

Further, about one in ten (10.5 percent) service area residents reported that those providers are not accepting new patients. Community partners repeated that while primary care providers are needed, there is an especially urgent need for care providers who accept Medicaid.

Given the described gap in follow up care, and the importance of follow care as previously described, the need to enhance this intervention by arranging follow up with the RAE within one business day of discharge, decreases the risk of the patient not having follow up care available – thus decreasing the risk that the patient will go untreated and return to the hospital unnecessarily. This proactive approach will lead to improved quality of life for the patient as well as lowered cost of healthcare.

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 Access			

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.