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: Cost and Utilization Reduction Program

Implement a program led by a committee comprised of both clinical and non-clinical leaders who will periodically analyze data sources consisting but not limited to readmissions, length of stay and avoidable procedural costs. Data will be used to identify areas of opportunity and used to drive continuous improvement efforts, which will be delegated to appropriate task forces, sub committees and/or service lines. Though Valley View is interested in overall costs savings and care efficiency for all populations and payer participants, a deeper evaluation on our Medicaid members will be a focus.

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. 1.SW-RAH1
2. 2. SW-COE1
3. 3. SW-PH1

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)

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)
These interventions are selected to assist the organization in creating a standardized forum to address opportunities of cost reduction by using data sources to identify areas that may be improved with better management of care and highlighting potentially avoidable costs. This forum will be a restructuring of an existing utilization review committee at Valley View.

The governance structure of the existing committee is comprised of clinical and non-clinical leadership with representation from administration, med staff, nursing, financial and quality. Responsibility of the Utilization and Cost Evaluation Committee will be to periodically review the readmissions, length of stay and hospital index data using validated data sources, including the Prometheus tool. The goal through data analysis will be to identify the top five weighted episodes that contribute to potentially avoidable costs, compare average length of stay against national and regional benchmarks for all service lines and identify chronic conditions and/or patients with the highest readmission rates. Further responsibility of the committee will be to coordinate with teams from different departments and/or service lines to communicate the identified gaps and/or high cost trends and provide oversight for improvement efforts. Valley View has adopted the PDSA (Plan, Do, Study, Act) tool to drive the continuous improvement implementation processes. Through this process, the continued review of data will determine when a clinical improvement shift has occurred and implement a change management strategy for sustainability. Data transparency throughout the process is a critical component in understanding every phase of this process to ensure buy-in and engagement at all levels and create a culture for continuous learning and improvement. Lastly, data will also be shared with our community healthcare partners to allow the medical neighborhood to provide feedback and contribute in the management of the patient through care management services that also aid with reduction with readmissions and lower overall healthcare costs.

We believe this intervention will advance the goals of the Hospital Transformation Program by improving both patient outcomes and patient experience through a mindful focus maintaining high quality care while reducing healthcare costs to bring value to our Medicaid patients. Through participation in the HTP framework, we are creating the ground work for Valley View's readiness for value-based payments by shifting the focus from what did we do to how well did the patient do? Striving for better outcomes sustained beyond discharge can lead to reduced costs through reduction in readmissions and avoidable care. This will be accomplished through collaboration amongst all healthcare partners, both inpatient and ambulatory, during each stage of an episode of care. Collaboration will be through data sharing and analytics, evidence-based care coordination and care transitions, and/or chronic care management.

The CHNE process enabled Valley View to grasp a better understanding of the community needs and perceived gaps at the local level. This process was invaluable and allowed us to make an informed decision on our measure and intervention selection. Of note, while the community did not specifically address healthcare costs as a core problem, Valley View's main vision is to be an independent healthcare leader, which our community does support. To keep this vision in focus, cost containment and reducing avoidable spending is a critical piece in this independence and will take high priority despite being overshadowed in our CHNE by other urgencies in which patients are affected by on a day to day basis.

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

There is no contradiction in literature to refute the fact that healthcare costs are on an unsustainable upward trajectory. The challenge we face is how to reduce healthcare costs without sacrificing quality or safety. This has led to several initiatives with aims to reduce overall spending by transitioning the traditional fee for service reimbursement model towards

one that rewards performance and/or improved patient outcomes as well as penalize organizations that do not. In essence, shifting the mindset from how much did the healthcare organization do to how well did the patient do.

To facilitate cost accountability, the Hospital Readmissions Reduction Program (HRRP) through the Affordable Care Act and the Hospital-Wide All Cause Readmission (HWR) under the Hospital Inpatient Quality Reporting (IQR) Program were put in place to link payment to quality of care (CMS, n.d.). Cost accountability efforts were refined again with a prospective payment system for inpatient care, which reimbursed hospitals for procedures based on the clinical features of the patient, a system known as diagnoses-related groups (DRG) payment. Length of stay is an included metric imbedded in the DRG calculation. Hospitals were reimbursed a set rate for a DRG group despite the cost of services provided. Through DRGs, the growth rate of inpatient hospital spending was reduced to that of general inflation. With passage of the Patient Protection and Affordable Care Act (ACA) in 2010, CMS instituted value-based purchasing (VBP). The approach rewards hospitals that meet quality performance targets and fines those that do not, as part of a larger plan to control hospital costs (Phillips, 2015).

In recent years, bundled payments have expanded beyond the hospital encounter DRG (inpatient costs) to including the entire episode of care (30 days prior and 90 days post encounter). Episode payment models incentivize participants to look across settings at the beneficiary's treatment needs – to improve coordination, reduce expenditures, and maintain or improve quality by thoughtfully determining optimal treatment processes and opportunities to deliver care more efficiently (CMS, 2020)An Episode of Care includes covered services spanning providers that would traditionally care for a patient's condition rather than segmenting the care encounters. Episode of Care definitions are a core element of the PROMETHEUS Analytics and one of their most discrete characteristic is the distinction of diagnosis codes considered as typical or routine, from those deemed to indicate a potentially avoidable complication. Additionally, benchmarks are created to grade the cost of the episode to determine if the organization gets to keep the difference or required to refund the payer (De Brantes, Francois, et al., 2010). This encourages hospitals to collaborate with community healthcare partners in enhanced communication and seamless transitions of care. Providing the patient the right care, at the right time, with the right provider is the aim.

Both delivery system transformation and payment reform concepts that fall under the Hospital Transformation Program framework are important for Valley View to capitalize upon the potential for savings. In order to meet HTP goals, it will be important for Valley View to centralize and standardize the analysis of readmissions, length of stay and hospital index to maximize staff resources and pave the way for continued independence to allow the organization and support the community in the best way possible.

Resources:

Center for Medicare and Medicaid Services (January 2020). CMS Innovation Center Episode Payment Models. Retrieved from https://innovation.cms.gov/files/reports/episode-payment-models-wp.pdf

Center for Medicaid and Medicare Services (n.d.). Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program

De Brantes, Francois et al. "Reducing potentially avoidable complications in patients with chronic diseases: The Prometheus Payment approach." Health services research vol. 45,6 Pt 2 (2010): 1854-71. doi:10.1111/j.1475-6773.2010.01136.x Link: https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1475-6773.2010.01136.x

Phillips VL (2015) Value-Based Purchasing in Healthcare: How the US Government is Securing Quality Improvement in Care in the United States. Review Pub Administration Manag 3: 158. doi:10.4172/2315-7844.1000158

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: Medicaid APM, Healthcare Policy and Finance (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)
Health Care Policy & Finance enabled hospitals to align with the statewide initiatives due to the Hospital Transformation Program's overall concept and framework. The predominant source of

alignment falls to the Accountable Care Collaborative (ACC) Phase II. Specifically, under the CHNE requirements, the ACC's Program Improvement Advisory Committee (PIAC) is referenced as an opportunity to leverage this platform to discuss the Hospital Transformation Program and we believe this initiative aligns with the PIAC's intentions.

Furthermore, the Alternative Payment Model for Primary Care (APM) is part of the Department's efforts to shift from paying for volume to paying for value across the entire delivery system. The APM is designed to support primary care providers through this shift. The Department, in close collaboration with stakeholders, has developed three goals for the APM: provide long-term, sustainable investments into primary care; reward performance and introduce accountability for outcomes and access to care while granting flexibility of choice to providers, and; align with other payment reforms across the delivery system.

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)
Valley View currently performs quality and cost analysis through several departments. The organization participates in several value- based initiatives amongst the inpatient space and the outpatient clinics, yet the evaluation and performance improvement efforts are often driven in silo. Likewise, it is challenging to integrate healthcare business teams and healthcare clinical teams in a way that fosters more powerful change. By using an interdisciplinary approach to team development could be the catalyst that determines successes versus struggle. Currently, the governance structure supports this approach. Furthermore, by centralizing the utilization and cost data review in the same venue could facilitate a streamlined approach towards improvement efforts.

8. a. Is this an existing intervention in use within the hospital ("existing interventions" are those interventions the hospital has implemented or is implementing on the day it submits the Hospital Application)?

☐ Yes

☒ No

b. If yes, please use the space below to explain how the following criteria for leveraging existing interventions is satisfied (the response may reference answers above):

- The hospital must demonstrate that the use of the existing intervention is the best approach for meeting the needs of the community identified during the Community and Health Neighborhood Engagement process.
- The hospital must demonstrate that the project will be enhanced to meet HTP goals.

Response (Please respond as applicable; Please seek to limit the response to 1,000 words or less)

9. a. Will the intervention be a joint effort with another organization (e.g., a Regional Accountable Entity, Local Public Health Agency, a mental or community health center, another community organization or any other external organization)?

☐ Yes

☒ No

Partnerships are not required, but, if the hospital will partner, please complete the remainder of this question and provide the required documentation (see subpart c).

b. If yes, please complete the following chart, including listing the partner organization; listing the type of organization; indicating whether the hospital has previously partnered with the organization; and providing a high-level summary of the expected role of the organization in intervention's leadership and implementation.

Partner Organization Name	Type of Organization	Does the hospital have any previous experience partnering with this organization? (Yes or No)	Organization's Role in Intervention Leadership and Implementation (high-level summary)

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.