



## Hospital Transformation Program (HTP) Application and Intervention Proposal

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## Overview

National Jewish Health is seeking feedback from the community stakeholders on its application for the Hospital Transformation Program (HTP). All feedback would be valued and taken into consideration for the planning and implementation of our HTP initiatives. Enclosed is the draft of the hospital application and interventional proposal including measure selection and identified interventions. Measure selection will focus on the following areas for HTP initiatives:

- Access to specialty care particularly for **children with Asthma and all ages with chronic respiratory conditions**
- Care coordination between the primary care provider and subspecialty provider
- Transition of care to appropriate follow up after hospital inpatient admission
- Identifying and addressing social determinants of health and behavioral health

Focus Area	Measure ID	Measure Name	Intervention
Reducing Avoidable Hospitalization Utilization	RAH1	Follow up appointment with a clinician made prior to discharge and notification to the Regional Accountable Entities (RAE) within one business day	<ul style="list-style-type: none"> <li>• Implement standardized referral for connection to clinician</li> <li>• RAE notification</li> </ul>
	RAH3	Home Management Plan of Care (HMPC) Document given to pediatric asthma patient/caregiver (eCQM)	Provide asthma patient/caregiver a home management plan of care (HMPC)
Core Population	SW-CP1	Social needs screening and notification	<ul style="list-style-type: none"> <li>• Implement standardized assessment and referral for social needs</li> <li>• RAE notification</li> </ul>
	CP7	Increase access to specialty care	Increase access to specialty care
Behavioral Health/Substance Use Disorder	SW-BH2	Pediatric screening for depression in inpatient and ED including suicide risk	<ul style="list-style-type: none"> <li>• Implement standardized assessment for pediatric inpatient depression and suicide risk</li> <li>• RAE notification</li> </ul>
Clinical and Operational Efficiencies	SW-COE1	Hospital Index	Create a standard approach to monitor potentially avoidable complications for Colonoscopy and EGD and continuous improvement
	COE1	Increase the successful transmission of a summary of care record to a patient's primary care physician (PCP) or other healthcare professional within one business day of discharge from an inpatient facility to home	Increase successful transmission of a summary of care record to patient's PCP
	COE3	Implementation/expansion of e-consults	Implementation/expansion of e-consults



## Hospital Transformation Program

### *Hospital Application*

1. Please use the space below to provide an executive summary clearly articulating how the hospital will advance the goals of the Hospital Transformation Program (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.

The executive summary should:

- Succinctly explain the identified goals and objectives of the hospital to be achieved through participation in the HTP; and
- Provide the hospital's initial thinking regarding how the HTP efforts generally can be sustainable beyond the term of the program.

Response (Please seek to limit the response to 750 words or less)

National Jewish Health (NJH) has identified four primary goals and objectives to be achieved from the participation in the HTP program that will ultimately improve the overall health outcomes of its patient population. Based on a combination of the surrounding community needs and NJH capabilities, the following goals and objectives have been identified as the primary focus of this effort that will also address the community health needs:

- Improve access to specialty care
- Improve health outcomes through care coordination and care transitions
- Improve health outcomes by identifying and addressing social determinants of health and behavioral health
- Increase collaboration among hospitals, providers and related stakeholders

NJH is a nonprofit specialty care hospital providing specialized services to patients with respiratory related illness. The identified goals will ultimately reduce unnecessary ED visits and hospital inpatient admissions primarily in the respiratory patients that we serve.



Based on collected data and identified community needs from the Community and Health Neighborhood Engagement (CHNE) process, NJH has selected specific measures and interventions to achieve the identified goals. NJH specific strategies and initiatives to improve the overall health outcomes of its patient population will be achieved by collaborating with internal and external stakeholders to implement various program improvement initiatives for respiratory patients. Projects will focus on identifying and addressing social and behavioral health needs, improving access to specialty care, and addressing care coordination and transitions of care between our patients and their primary care providers.

Ultimately, the goal is to establish long-term and sustainable solutions to achieve desirable patient health outcomes through coordinated efforts, shared data, and improved partnership. The formed alliance will focus on community needs that will ultimately address underlying factors to reduce unnecessary emergency department (ED) visits and avoidable hospital utilization among the patient population. Unnecessary ED visits and avoidable hospital utilization account for significant costs that may be otherwise avoided by linking patients to appropriate primary care or specialty services, by promoting preventive care, and by addressing social factors impacting health outcomes. Additionally, enhanced data sharing and two-way communication across the care continuum will address the challenges associated with lack of information integration: the duplication of services, gaps in service, and sub-optimization of resources. Hospital transformation is impossible without the ability to effectively share information among stakeholders. Without shared data, providers and community-based organizations cannot effectively access information on the patients and populations they are treating, undermining care coordination and population health management efforts.

National Jewish Health will continue to work with the RAEs (Regional Accountable Entity) and other community stakeholders/organizations to address social and behavioral health needs, to improve access to specialty care and to improve health outcomes through care coordination and effective transitions of care. Partnering with the RAEs is crucial in coordinating joint efforts to address specific community care needs that have been identified from our CHNE process for improvement of health outcomes that will ultimately reduce health costs. This approach along with NJH being a specialty care facility will guarantee desirable outcomes for the HTP program.

- Provide the hospital's initial thinking regarding how the HTP efforts generally can be sustainable beyond the term of the program.

National Jewish Health's goal is to establish and promote an integrated system, with coordinated approaches and services, to achieve sustainability on its identified measures and interventions that will continue beyond the term of the program. NJH has recognized that the system is fragmented and to preserve its HTP efforts, it must institute an approach that will improve system integration by co-locating services and taking a community-based approach to care. Transformation to an integrated system will be achieved through meaningful and sustainable partnerships to develop lasting programs and infrastructure by leveraging existing resources to improve efficiency and to manage health outcomes.

NJH will integrate its HTP efforts into the organization's QAPI plan as part of the organizational priorities for ongoing performance monitoring, reporting, review and analysis, and improvement. This approach will ensure that all HTP efforts align with NJH's overall goals and objectives and are included as part of the organizational resource planning and management. Leveraging existing



resources and expertise to manage HTP efforts will allow NJH to transform the program into a sustainable program. Additionally, integration of its HTP efforts will allow NJH to apply a value-based payment approach to other service areas that will eventually improve efficiency and sustainability.

NJH plans to continue to work with the RAEs and other community stakeholders/organizations to establish lasting programs and approaches that will enhance integration and improve community health outcomes. Once a common care management system is established among stakeholders, the sharing of resources, data and expertise will improve care coordination and care transitions in a sustainable manner for the patient population beyond the term of the program. NJH and its partners will work together to transform the system by linking patients to appropriate primary care, specialty services and community resources; by promoting preventive care; and by addressing social factors impacting health outcomes. This approach will eventually reduce unnecessary ED visits and avoidable hospital utilization, all of which will ultimately lower costs in the long run.



2. Please provide the legal name and Medicaid ID for the hospital for which this Hospital Application is being submitted, contact information for the hospital executive, and a primary and secondary point of contact for this application.

Hospital Name: National Jewish Health

Hospital Medicaid ID Number: 05000112

Hospital Address: 1400 Jackson Stree, Denver Co 80206

Hospital Executive Name: Michael Salem

Hospital Executive Title: President/CEO

Hospital Executive Address: 1400 Jackson Street, Denver, CO 80206

Hospital Executive Phone Number: 303-398-1031

Hospital Executive Email Address: sailemm@njhealth.org

Primary Contact Name: Candace Juarez

Primary Contact Title: Quality Manager

Primary Contact Address: 1400 Jackson Street, Denver CO 80206

Primary Contact Phone Number: 303-398-1843

Primary Contact Email Address: juarezc@njhealth.org

Secondary Contact Name: Jeff Downing

Secondary Contact Title: Manager of Risk Management and Service Excellence

Secondary Contact Address: 1400 Jackson Street, Denver CO 80206

Secondary Contact Phone Number: 303-398-1766

Secondary Contact Email Address: downingj@njhealth.org



3. a. Please use the space below to describe the planned governance structure for the hospital's HTP engagement and how it will align with the hospital's overall project management capabilities. A description of the governance structure that will be put in place to support the hospital's HTP engagement;

Response (Please seek to limit the response to 250 words or less)

National Jewish Health (NJH) has formulated a delegated governance structure that allows for broad representation and input. Our governance model is centered around an inclusive, transparent committee structure and process with representation of all partners including senior leadership, physicians and physician leadership, nursing leadership, clinical affairs, finance, IST, and Quality.

The HTP Steering Committee and HTP subcommittee workgroups are the central control points for all HTP efforts. The HTP Steering Committee will oversee the planning and implementation of projects through collaboration with providers and staff across the continuum of care. The HTP Steering Committee is responsible for removing system barriers, providing direction to the various workgroups and ensuring the HTP efforts are implemented and maintained.

- b. How the planned structure has been adapted to the needs and unique experiences of the hospital and how it will ensure successful oversight of the hospital's HTP engagement;

Response (Please seek to limit the response to 250 words or less)

National Jewish Health specializes in respiratory care for our community of patients. Our HTP Steering Committee has identified different workgroups for each measure to focus our efforts for this program. Each workgroup will collaborate with community organizations or workgroups and staff and associated leaders, within the hospital, to review, design and implement new workflows, develop implementation plans and meet outlined milestones. The HTP Steering Committee will provide guidance and leadership to the workgroups in the planning and implementation of these projects. This will create a structure for data management, process evaluation and performance improvement that aligns with our hospital PDCA (plan, do, check, act) performance improvement program. The workgroups will be reporting to the HTP Steering Committee on a quarterly basis to ensure we are meeting the intent of each measure and to monitor our progress toward implementing successful and sustainable improvement efforts.

- c. Specifically, how the structure will ensure management and transparency and engage members of impacted populations and community partners;

Response (Please seek to limit the response to 250 words or less)

The HTP Steering Committee, at National Jewish Health, has reviewed our Community Needs Assessment to identify specific needs in our patient population and the community. These needs, as well as recommendations from the community stakeholder initiative will help to provide guidance to meet the needs of impacted populations and community partners. By collaborating with the RAE's and other community partners, we plan to improve transitions of care and increase access to specialty care to the community for those suffering with respiratory related illnesses. Improving these transitions with the primary care provider and the RAEs will decrease ER visits and hospitalizations. Both leadership and transparency will be ensured through the efforts of our HTP Steering Committee, workgroups and community partners by continuing to engage in ongoing CHNE work. Our plan for community engagement includes meetings with our community members, publishing our application and intervention proposal on our website for feedback and engaging



organizations and partners in assessing the effectiveness of our actions to determine if we are meeting the needs of an ever changing community. By participating in this HTP structure and framework, we believe we can reduce costs and achieve a more transparent and effective care model for our patients and community.

- d. The overall project management structure of the hospital, including how it is organized into operational, clinical, financial, and other functions, and how it will be leveraged to support the hospital's efforts under the HTP and the governance of those efforts;

Response (Please seek to limit the response to 250 words or less)

The HTP Steering Committee is comprised of leaders throughout the organization who can make operational, clinical and financial decisions to promote improvement of the care and services we provide to our patients and to our community partners. Having the workgroups reporting to the Steering Committee will provide insight on identified needs to implement processes for these processes. Our HTP Steering Committee consists of hospital executive leadership who are committed to improving the health of our patients. Many of these leaders are highly involved with performance improvement initiatives throughout the organization. Our Mission is to heal, to discover and to educate as a preeminent healthcare institution. Our vision is to be the global leader in the research and treatment of pulmonary, cardiac and immune diseases. Collaborating with our community partners to improve healthcare outcomes and transitions of care will help to decrease ER visits hospitalizations, improve health outcomes and meet the mission and values of our organization.

- e. How the hospital's project management structure is aligned with the hospital leadership structure; and

Response (Please seek to limit the response to 250 words or less)

The HTP Steering Committee is our hospital leadership who will provide the guidance, structure and leadership to meet the intent of this HTP program in order to provide ongoing and continued improved care to patient with respiratory illnesses. The Quality department is involved in the management and implementation of all improvement efforts. The Quality department will work in collaboration with the workgroup and various departments on data collection, data review and analysis, data presentation and reporting. The HTP measures have been identified as priorities for quality monitoring and are part of our Quality Assessment and Improvement Program. Goals data, results and all improvement efforts will be reported to hospital leadership quarterly or as needed. Data will be provided utilizing dashboards and graphs to outline our progress in meeting identified goals.

- f. The current state of centralized reporting capabilities for the hospital.

Response (Please seek to limit the response to 250 words or less)

**Operational, financial clinical and quality information are reported to various clinical leaders, the medical staff and the Board of Directors quarterly. NJH follows a PDCA cycle for performance improvement analysis and review. The Quality department provides direction and management for the improvement efforts within the institution. Our HTP program will be in alignment with our performance improvement program to maintain improvement efforts and sustainability. Currently we are using Allscripts as our EMR but will moving toward implementation of Epic the end of 2021. Most of our data for HTP and other quality initiatives will come from EMR reports**





and the REDCap reporting system. Our IST department will be instrumental in providing the means to capture and record data for analysis and review.

4. Please use the space below to describe the hospital’s plan for continuing Community and Health Neighborhood Engagement throughout the hospital’s HTP participation. A detailed plan is not required. Instead, hospitals can outline a high-level approach to CHNE going forward, including, for example, the stakeholders to be engaged and the types and frequency of activities to be used. Hospitals should consult the Continued Community and Health Neighborhood Engagement document, which can be found on the [HTP webpage](#), to ensure their planned activities fulfill program requirements.

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

As one of the leading respiratory hospital combining our medical expertise and knowledge to find ways to treat and care for patients, we value our patients, community partners and stakeholders feedback and recommendations to improve the health of our patients. National Jewish Health plans to include the following stakeholders and engagement activities in the plan for ongoing community and health neighbor engagement and feedback:

1. Partner with Metro Denver Partnership for Health (in collaboration with public health departments, human service agencies, healthcare systems and Regional Accountable Entities in the Denver metro area) in the development of a regional Social Health Information Exchange (SHIE). SHIE bridges the gap between clinical areas and community-based organizations/community resources to support ongoing screening, referral, and coordination of social needs.
2. Regional Accountability Entities (RAEs) through the PIAC meeting.
3. Leverage the Public Community Meeting requirement under Colorado Revised Statutes Title 25.5-1-702 for HB1320.

Ongoing community engagement is vital in the identification of new community needs that could be a contraindication to HTP efforts.

5. As part of continuing Community Health Neighborhood Engagement (CHNE), hospitals must share a draft of their application with stakeholders to allow them the opportunity to provide feedback for hospitals’ consideration. This Public Input process must last at least 10 business days, with an additional 5 business days allotted to hospital review and response to any Public Input received. Hospitals must submit applications by **[DATE]**, but hospitals may resubmit revised applications with revisions based solely on feedback from the Public Input process by **[DATE]**. The Department of Health Care Policy & Financing will also make submitted applications public once applications are complete and approved by the review board. Please refer to the Ongoing CHNE Requirements document on the Hospital Transformation Program website for a list of key stakeholder categories. At a minimum, the stakeholders should include those who engaged in or were invited to engage in the CHNE process.

Has the Public Input process been completed and does this draft incorporates any potential revisions based on that public feedback:

- Yes
- No



Please enter the dates of your proposed or completed Public Input timeline. If you have not yet completed your Public Input process by the initial submission deadline of April 30, 2020, please fill in proposed dates. You will need to fill in the actual dates when you resubmit your application at the conclusion of the Public Input process by May 21, 2020. Please use **mm/dd/yyyy** format.

Proposed Public Input Period : 2/7/2021 to 2/28/2021

Proposed Hospital Review of Public Input Period: 3/1/2021 to 3/30/2021

Actual Public Input Period : \_\_\_\_ to \_\_\_\_

Actual Hospital Review of Public Input Period: \_\_\_\_ to \_\_\_\_

*If you answered no to the above question and your submission is subject to change based on an ongoing Public Input process, please note that you must turn in your revised application by May 21, 2020. After incorporating your Public Input process changes, applicants are required to submit both a clean and a red-lined version of the Hospital Application to aid HTP review staff in identifying the Public Input based changes compared to your initial submission.*

Please use the spaces below to provide information about the hospital’s process for gathering and considering feedback on the hospital’s application.

Please list which stakeholders received a draft of your application and indicate which submitted feedback.

Response (Please seek to limit the response to 250 words or less)

Organization Name	Organizational Contact	Organization Type	Engagement Activity	Connection to any specific HTP priority populations and / or project topics, as applicable
Colorado Access	Daniel Obarski, Molly Markert	RAE	Focus Group	High Utilizers, Total Cost of Care, coordination, service availability, social determinants of health, behavioral health
Colorado Community Health Alliance	Hanna Thomas, Jessica Rink	RAE	Focus Group	High Utilizers, Total Cost of Care, coordination, service availability, social determinants of health, behavioral health
City and County of Denver	Tristan Sanders	Local Public Health Agency	Focus Group	Population health, maternal child health, social determinants of health, behavioral health
Jefferson County Public Health	Kelly Kast, Melissa Palay	Local Public Health Agency	Focus Group	Population health, maternal child health, social determinants of health, behavioral health
Tri-County Health Department	Emma Goforth, Heather Baumgartner	Local Public Health Agency	Focus Group	Population health, maternal child health, social determinants of health, behavioral health
Denver Public Health	Jessica Forsyth, Kellie Teter	Local Public Health Agency	Focus Group	Population health, maternal child health, social determinants of health, behavioral health
Jefferson Center for Mental Health	Don Bechtold	Behavioral health organization	Focus Group	Behavioral health, Substance Use
AllHealth Network	Cynthia Grant	Behavioral health organization	Focus Group	Behavioral health, Substance Use



Signal Behavioral Health	Heather Dolan	Behavioral health organization	Focus Group	Behavioral health, Substance Use
Center for Health Progress	Christopher Klene	Community organizations addressing social determinants of health	Focus Group	Social supports
Hunger Free Colorado	Sandy Nagler, Brett Reeder	Community organizations addressing social determinants of health	Focus Group	Social supports
Center for African American Health	Deidre Johnson	Community organizations addressing social determinants of health	Focus Group	Social supports
Broomfield FISH	Dayna Scott	Community organizations addressing social determinants of health	Focus Group	Social supports
Mile High Health Alliance	Dede de Percin, Karen Trautman, Alyssa Harrington	Health Alliance	Focus Group	Social supports, care transitions, health data infrastructure, advocacy
Aurora Health Alliance	Mandy Ashley	Health Alliance	Focus Group	Social supports, care transitions, health data infrastructure, advocacy
Adams County Health Alliance	Meghan Prentiss	Health Alliance	Focus Group	Social supports, care transitions, health data infrastructure, advocacy
Douglas County Health Alliance	Wendy Nading	Health Alliance	Focus Group	Social supports, care transitions, health data infrastructure, advocacy
Boulder County Health Improvement Collaborative	Morgan McMillan	Health Alliance	Focus Group	Social supports, care transitions, health data infrastructure, advocacy
Community Health Centers	Multiple representatives from the metro region	Federally Qualified Health Centers	Focus Group	Access, primary care, social determinants, behavioral health, mothers and infants, care coordination
CORHIO	Morgan Honea, Kate Horle	Regional Health Information Exchange	Key Informant Interview	Health data exchange infrastructure
InnovAge	Beverley Dahan	Long Term Services and Supports Provider	Key Informant Interview	Older adults/end of life, care transitions, primary care
Colorado Coalition for the Homeless	Brian Hill	Primary Care Medical Provider/Community Organization	Key Informant Interview	Care transitions, high utilizers, behavioral health, disconnected from system
Colorado Cross-Disability Coalition	Julie Reiskin, Dawn Howard	Consumer advocate	Key Informant Interview	Consumer advocacy, long-term services and supports, access, care transitions, high utilizers
Colorado Criminal Justice Reform Coalition	Terri Hurst	Consumer advocate	Key Informant Interview	High utilizers, care transitions, behavioral health, social supports, disconnected from system
Colorado Children's Campaign	Erin Miller	Consumer advocate	Key Informant Interview	Maternal child health, social supports
Every Child Pediatrics	Jessica Dunbar	Primary Care Medical Provider	Key Informant Interview	Access, primary care, social determinants, behavioral health, mothers and infants, care coordination



Denver Regional Council of Governments	Ron Papsdorf, Jayla Sanchez-Warren	Community organizations addressing social determinants of health	Key Informant Interview	Social determinants of health, long-term services and supports
Mile High & Foothills RETAC	Bill Clark	RETACs	Key Informant Interview	High Utilizers

Please explain how the draft application was shared and how feedback was solicited.

Response (Please seek to limit the response to 250 words or less)

Hospitals collaborated with the Colorado Health Institute (CHI) to solicit review and feedback for the HTP application process. CHI sent an email to our community stakeholders providing email links to the HTP webpage for each hospital. To facilitate this review, each hospital provided a short summary of their application, their draft application and their intervention proposals, including intervention evidence, alignment with community needs and experience with the proposed intervention along with a list of their community partners. Based upon feedback obtained for our community stakeholders review, the application and intervention will be revised to further meet the needs of our community.

With a bulleted list, please list the shared stakeholder feedback and explain if any changes were made to the application based on the feedback. If no changes were made, please explain why. If the same or similar feedback was shared by more than one stakeholder, please list it only once.

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

-

*Please consult the accompanying Intervention Proposal before completing the remainder of this application.*

6. Please use the space below to identify which statewide and local quality measure(s) from the [HTP Measure List on the Colorado Hospital Transformation Program website](#) the hospital will address for each Focus Area.

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.



As applicable, please identify the Statewide Priority your hospital is pursuing as a part of the HTP Hospital Application:

- SP-PH1 - Conversion of Freestanding EDs
- SO-PH2 - Creation of Dual Track ED

Please note that hospitals are required to complete the accompanying Intervention Proposal for the statewide priorities identified above.

The selections should align with the hospital's improvement priorities and community needs. As a reminder, hospitals must adhere to the following requirements when selecting quality measures:

- 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.

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: Follow up appointment with a clinician made prior to discharge and notification to the Regional Accountable Entities (RAE) within one business day
2. RAH3: Home Management Plan of Care (HMPC) Document Given to Pediatric Asthma Patient/Caregiver (eCQM)



3. SW-CP1: Social Needs Screening and Notification
4. CP7: Increase access to specialty care
5. SW-BH2: Pediatric Screening for Depression in Inpatient and Emergency Department Including Suicide Risk
6. SW-COE1: Hospital Index
- 7: COE1: Increase the successful transmission of a summary of care record to a patient's primary care physician or other healthcare professional within one business day of discharge from an inpatient facility to home
- 8: COE3: Implementation/Expansion of e-Consults

7. Please use the space below to identify all of the hospital's proposed interventions. Following each listed proposed intervention, please identify which of the measures from the response to Question 6 will be addressed by that intervention. Please list the unique identification code listed in response to Question 6 to identify the applicable measures and please format your response in accordance with the following example:

1. Intervention Name
  - a. Measures: SW-RAH1, RAH2

Response (Please format the response as a numbered list)

1. Follow-up appointment with PCP prior to discharge and RAE notification
  - a. Measure(s): RAH1
2. Provide asthma patient/caregiver a home management plan of care (HMPC)
  - a. Measure(s): RAH3
3. Implement standardized assessment and referral for social needs and RAE notification
  - a. Measure(s): SW-CP1
4. Increase access to specialty care
  - a. Measure(s): CP7
5. Implement standardizes assessment for pediatric inpatient depression and suicide risk
  - a. Measure(s): SW-BH2
6. Create a standard approach to monitor potentially avoidable complications for Colonoscopy and EGD and continuous improvement
  - a. Measure(s): SW-COE1



7. Increase successful transmission of a summary of care record to patient's PCP

a. Measure(s): COE1

8. Implementation/expansion of e-consults

a. Measure(s): COE3



## Measure Selection and Intervention Proposal

### RAH1 - Follow-Up Appointment with PCP Prior to Discharge

Percentage of Medicaid patients discharged from an inpatient admission to home with a documented follow up appointment with a clinician and notification to the RAE within one business day.

1. **Name of Intervention:** Follow-up appointment with PCP prior to discharge and RAE notification
2. **Measure Selection:** RAH1
3. **Intervention Description and Rationale Including Target Population for the Intervention and How the Intervention Advances the Goals of the HTP:**

Good care coordination for follow-up appointment post discharge is a key factor in reducing avoidable ER visit and hospitalization utilization.

Many factors affect the readmission rate among patients. One of these factors is the lack of outpatient follow-up care post discharge. During our CHNE process, multiple partners shared the concern that a transition is only successful if services are available for the patient when they are ready to access them. Additionally, ensuring a connection between a patient and a community/external provider or organization, that provides the on-going care, before that patient is discharged from the hospital is key to ensuring successful transitions. Partners described the challenges, difficulties, and time required to connect with or find patients if there isn't integration between inpatient and outpatient care. This lowers the likelihood that patients will receive the care and support needed to avoid a readmission or ED visit. There are 10 key components to an Ideal Transition of Care including:

1. Discharge planning
2. Complete communication of information
3. Availability, timeliness, clarity, and organization of information
4. Medication safety
5. Education patients to promote self-management
6. Enlisting help of social and community supports
7. Advance care planning
8. Coordinating care among team members
9. Monitoring and managing symptoms after discharge
10. Outpatient follow-up

Our identified intervention to schedule a follow-up appointment with the PCP prior to discharge will help promote an ideal transition of care and reduce readmission rates related to inadequate transition of care.

4. **Describe How the Intervention and Selected Measure Align with Community Needs:**

Care coordination post discharge provides the patient with the ability to have their primary care provider (PCP) review their medications and treatment plan to determine the effectiveness of their treatment. Patient compliance and on-going education related to their disease can prevent acute patient asthma and COPD exacerbations which can lead to ER visits or hospitalizations. Key findings



from our community health provider surveys indicated issues with community provider follow-up and the challenge of managing patients with chronic diseases such as asthma and COPD due to their need for ongoing care, appointments and complexity of treatment regimes. Aligning our post discharge efforts with the patient's primary care provider can help patients receive the follow-up care that is needed for ongoing patient support in their overall health outcomes.

Best practice for this measure is to work with the patient and the PCP to set a follow-up appointment before the patient is discharged. Including the patient in this process engages the patient with their own care and increases the likelihood of the patient adhering to their appointment. Communication with the RAE will help in transitioning the follow-up care to the PCP by providing the medical and clinical information they need in order to best care for the patient. Aligning our efforts with the RAE and PCP will help to provide patient support and management in following an outlined treatment plan that is specifically tailored to meet the patient's needs for improving their health. Building these relationships allows us to provide care coordination and decrease lapses in care for those patients in our community.

**5. Evidence Base:**

- Kripalani, S., Theobald, C.N., Anctil, B. & Vasilevskis, E.E., 2014. Reducing hospital readmission rates: current strategies and future directions. *Annual Review of Medicine*. 65, 471-85.
- Backer, V., Bornemann, M., Knudsen, D. & Ommen, H., 2012. Scheduled asthma management in general practice generally improve asthma control in those who attend. *Respiratory Medicine*. 106 (5), 635-41.
- Schatz, M., Rachelefsky, G. & Krishnan, J.A., 2009. Follow-up after acute asthma episodes: what improves future outcomes? *Journal of Allergy and Clinical Immunology*. 124 (2 Suppl): S35-42.
- Ruffner, M.A., Henrickson, S.E., Chilutti, M., *et al.*, 2018. Improving allergy office scheduling increases patient follow up and reduces asthma readmission after pediatric asthma hospitalization. *Annals of Allergy, Asthma and Immunology*. 121 (5), 561-567.

**6. Does Proposed Intervention Intersect with Ongoing Initiatives Statewide? If Yes, Identify:**

There are several statewide initiatives working on interventions for the coordination of care.

- HQIP
- MDPH - SHIE

**7. Does Hospital or Affiliated Community Partner(s) Have Experience with Intervention and/or Core Population? If So, How Does the Experience Support the Success of the Intervention?**

Our previous process for notification with the patient's RAE was time consuming, labor intensive and fragmented. We do not have the technical capabilities to allow for a standard and efficient exchange of information. By collaborating with the SHIE workgroup and the RAEs, we hope to be able to implement a systems exchange process for this transmission of information. This can allow for better coordination of care between the primary and specialty care providers.

**8. Is This an Existing Interventions? If Yes, Explain: No, new intervention.**

### 9. Will the Interventions Be a Joint Effort with Another Organization?

National Jewish Health will be working primarily with the MDPH SHIE workgroup to develop a coordinated exchange of health information to the RAEs and primary care providers. Most of our inpatient population belong to the Colorado Access region so we will be partnering with Colorado Access to outline and implement this intervention.

#### RAH3 – Home Management Plan of Care

An assessment that there is documentation in the medical record that a Home Management Plan of Care (HMPC) document was given to the pediatric asthma patient/caregiver.

1. **Name of Intervention:** Provide asthma patient/caregiver a home management plan of care (HMPC)

2. **Measure Selection:** RAH3

3. **Intervention Description and Rationale Including Target Population for the Intervention and How the Intervention Advances the Goals of the HTP:**

Asthma is the most common chronic disease in children. For children, asthma is one of the most frequent reasons for admission to hospitals. Lack of proper self-management and education are contributing factors to asthma exacerbation resulting in ER visits and hospitalization. Organization of care towards patient self-management, including patient/caregiver education on appropriate use of asthma medications and identification of symptoms and triggers that can lead to a worsening respiratory status, can improve outcomes in asthma patients as they learn to manage their disease.

4. **Describe How the Intervention and Selected Measure Align with Community Needs:**

At National Jewish Health, asthma represents the most common diagnosis among our patients followed by other respiratory diagnosis including bronchiectasis, pulmonary interstitial glycogenosis, interstitial lung disease, chronic obstructive pulmonary disease, and other respiratory infections. Asthma is the most common chronic disease in children and accounts for the most missed school days. According to the U.S. Centers for Disease Control and Prevention (CDC), asthma rates are higher among children, especially those who are poor, male and/or African American. In Colorado, current asthma rates are 9.0 percent among adults and 7.3 percent in children. In the National Jewish Health community, asthma rates are above average in Adams, Jefferson and Douglas counties. Uncontrolled asthma, as evidenced by emergency room visits and hospitalizations, is highest in Adams, Arapahoe and Denver counties. The Colorado Department of Public Health and Environment notes that prevalence of asthma in children and adults is greater among those on Medicaid. Surveys of community health providers and National Jewish Health experts noted pediatric asthma as an especially significant health need. Both patients and providers could benefit from additional education about respiratory diseases, their symptoms and how to diagnose and manage them. National Jewish Health has a wealth of knowledge and

expertise on respiratory diseases and the evidence-based strategies to manage them. According to the CDC, the most effective methods of asthma control and management include:

- Reducing exposure to triggers
- Treating patients with appropriate medications such as inhaled corticosteroids
- Educating patients and caregivers
- Improving asthma management in schools
- Identifying and sharing best practices
- Targeting interventions to populations disproportionately affected by asthma

Visiting the ED for an asthma exacerbation is a key indicator of poorly controlled asthma and of risk for future asthma exacerbations. Focused and targeted patient/care giver education along with an outlined asthma action plan help prevent future ED visits by providing the tools and knowledge to effectively manage their asthma symptoms. Therefore, it is significantly vital to provide patients or caregivers clear written instructions at time of discharge to promote self-management as a cornerstone in asthma control to prevent unnecessary ED visits and hospitalizations.

**5. Evidence Base:**

- Asthma Surveillance Summaries, 2013. Centers for Disease Control and Prevention (CDC). Available at: [https://www.cdc.gov/asthma/surveillance\\_summaries.htm](https://www.cdc.gov/asthma/surveillance_summaries.htm). (Last accessed: 02/04/2021)
- Zipkin, R., Schrager, S.M., Nguyen, E., *et al.*, 2017. Association between pediatric home management plan of care compliance and asthma readmission. *The Journal of Asthma*. 54 (7), 761-767.
- Zipkin, R., Schrager, S.M., Keefer, M., *et al.*, 2013. Improving home management plan of care compliance rates through an electronic asthma action plan. *The Journal of Asthma*. 50 (6), 664-671.
- Yeung, T.Y., Ewing, C., Malanowska, A., *et al.*, 2018. Home management of childhood asthma exacerbations. *Pulmonary Therapy*. 4 (2), 149-157.

**6. Does Proposed Intervention Intersect with Ongoing Initiatives Statewide? If Yes, Identify:**

Home Management of Plan of Care for pediatric asthma patients is an ongoing intervention we report to Joint Commission, for Oryx requirements, and to CMS for inpatient reporting. We have developed very detailed Home Management Plans for our day patient population and are currently incorporating key components into our inpatient discharge instruction plans.

**7. Does Hospital or Affiliated Community Partner(s) Have Experience with Intervention and/or Core Population? If So, How Does the Experience Support the Success of the Intervention?**

We do have extensive experience developing Asthma Action Plans and school-required management forms for pediatric asthma patients. We will use our Home Management Care Plan from our day patient process as a model for our inpatients. Incorporating the Asthma Action Plan and outlining the use for each medication to our discharge instructions will provide a more effective set of instructions for the patient.

**8. Is This an Existing Interventions? If Yes, Explain:** Yes, existing intervention.

**9. Will the Interventions Be a Joint Effort with Another Organization? No**

**SW-CP1 – Social Needs Screening and Notification**

Measurement of the number of Medicaid patients discharged to home from an inpatient admission who have formal social needs screening during or within 12 months of the admission, results documented in the medical record and, if there is a positive social needs screen, referral to an appropriate entity and notification to the RAE utilizing a process that is mutually agreed upon

**1. Name of Intervention:** Implement standardized assessment and referral for social needs and RAE notification

**2. Measure Selection:** SW-CP1

**3. Intervention Description and Rationale Including Target Population for the Intervention and How the Intervention Advances the Goals of the HTP:**

This intervention addresses the social determinants of health (SDOH) screening and referral to the RAE for any positive screens. Healthy People 2020 defines the social determinants of health as “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.” Social determinants of health and the effects on patients can impact their care and health outcomes. Progress has been made in assessing these risk factors but there are still challenges in creating a standardized process that can effectively and efficiently cross the fragmented healthcare system to adequately address the needs of the patient. A growing number of studies on asthma are beginning to define the underlying mechanisms that connect social determinants to human disease.

The five domains include housing instability, food insecurity, transportation issues, utility needs and interpersonal safety. Three components/steps/phases to this intervention:

- Screen
- Referral
- RAE notification

Our intention is to identify a screening tool, outline the internal workflow and implement the appropriate referral platform. By working with our community partners and the RAEs, we hope to be able to customize referrals based on the needs of the patient. We feel that by integrating these services into our care practices, we can improve patient outcomes and care coordination.

**4. Describe How the Intervention and Selected Measure Align with Community Needs:**

- Nearly all community partners identified housing as one of the most significant gaps in social supports for HTP priority populations. This ranged from safe housing environments, especially for

older adults or frail elderly as well as children with special health care needs. The overall lack of affordable housing in the metro area, including limited apartment capacity, was identified as especially acute for low income Medicaid enrollees. The rise in unemployment or under-employment has led to increased homelessness with this lack of affordable housing.

- Community partners described how low-income populations in the metro area struggle with food insecurity and its impacts on poor health outcomes. Many members of our community do not have access to high quality food because they may live in area with few grocery stores or the cost of food is too high for them to afford.
- Transportation was identified as one of the high priorities, as evidenced by the high ranking of the Comprehensive Respiratory Care Clinic in community focus groups. Lack of transportation can be a barrier for patients getting to and from their appointments. Individuals who rely on public transportation may have difficulty getting to their appointments in a timely manner.
- Surveys from our community health providers noted that the cost of medications and the home environment were the biggest challenges for pediatric asthma patients.

#### 5. **Evidence Base:**

- National Alliance to Impact the Social Determinants of Health. 2020. Identifying Social Risk and Need in Health Care: Promising Approaches to Screening for Social Determinants of Health & Recommendation for Continued Exploration. Available at: <https://www.nasdoh.org/wp-content/uploads/2019/01/NASDOH-Social-Risks-Issue-Brief.pdf>. (Last accessed 04/02/2021).
- Health Research & Educational Trust, 2017. Hospital-community partnerships to build a Culture of Health: A compendium of case studies. Chicago: Health Research & Educational Trust. Available at <https://www.aha.org/system/files/hpoe/Reports-HPOE/2017/hospital-community-partnerships-case-study-compendium.pdf>. (Last accessed: 04/02/2021).
- Institute of Medicine, 2014. Capturing social and behavioral domains and measures in electronic health records: Phase 2. Washington, DC: The National Academies Press. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK268995/>. (Last accessed 04/02/2021).
- Healthy People, 2020. Social Determinants of Health. Available at: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>. (Last accessed: 04/02/2021).
- Andermann, A., 2018. Screening for social determinants of health in clinical care: moving from the margins to the mainstream. *Public Health Review*. 22 (39), 19.

#### 6. **Does Proposed Intervention Intersect with Ongoing Initiatives Statewide? If Yes, Identify:**

There is a statewide workgroup focusing on Social Health Information Exchange. The purpose is to connect clinical and non-clinical providers to support person-centered care coordination.

#### 7. **Does Hospital or Affiliated Community Partner(s) Have Experience with Intervention and/or Core Population? If So, How Does the Experience Support the Success of the Intervention?**

No.

#### 8. **Is This an Existing Interventions? If Yes, Explain:** No, new intervention.

#### 9. **Will the Interventions Be a Joint Effort with Another Organization?**

One of our community's highest priorities is addressing social needs that many in our community deal with daily. This intervention will allow us to partner with the RAEs and other community organizations to provide on-going support after discharge. We will be working with Colorado Access for RAE notification of social determinants of health. We will also be working with additional community partners to determine resources for patients as well as implementing processes for the exchange of social health information. By collaboration with other organizations, we can address barriers that prevent patients from receiving the care they need in order to manage their health conditions.

### CP7 – Increase Access to Specialty Care

The annual number of Medicaid visits with specialist physicians contracted through or employed by a hospital.

1. **Name of Intervention:** Increase access to specialty care
2. **Measure Selection:** CP7
3. **Intervention Description and Rationale Including Target Population for the Intervention and How the Intervention Advances the Goals of the HTP:**

Our CHNE process identified community health needs into two categories: respiratory health and social and behavioral health. Asthma and COPD are the two most common and burdensome respiratory diseases in our community. Tobacco use, air pollution, education for providers and patients access to specialty care and cost of medications and care are the most significant social and behavioral health needs in our community.

The ease and speed of referral to specialists are a major concern for patients and primary care providers. Patients get frustrated and dissatisfied with the referral process and have a level of distrust and confidence in this process. This is more evident with patients who have chronic conditions, such as asthma or COPD, conditions that may require more specialized care. Patients may seek care elsewhere such as ER or urgent care but little follow-up occurs after these visits for continued care.

A previous project implemented at National Jewish Health was a pilot three-year clinic, Comprehensive Respiratory Care Clinic, for under-served and under-insured patients. Patient self-reported statistics demonstrated a 19% decrease in ED visits and a 23% decrease in pulmonary related hospitalizations during the course of this clinic. Coordinating the care for these patients improved patients' appointment attendance which increased our ability to care for the patients ongoing needs.

4. **Describe How the Intervention and Selected Measure Align with Community Needs:**

The metro Denver area has limited access to specialty care providers for all individuals, according to some community partners. But Medicaid enrollees are especially underserved given the high demand for services.

One partner described access to specialty care for Medicaid enrollees as “a nightmare”. Unique specialty needs include pulmonary, asthma, allergy, immunology, cardiology, orthopedics, neurology, gastroenterology, dermatology, oncology, and any surgical care. As a specialty care provider, National Jewish Health is in the position to fill this gap in care. Construction on Our Center for Outpatient Health will be completed in the fall and this will increase our capacity to see patients with respiratory related illness. We continue to collaborate with Saint Joseph Hospital and Rocky Mountain Hospital to deliver specialized care and expertise at more locations across Colorado. Current expansion of programs for pulmonary hypertension, scleroderma and amyotrophic lateral sclerosis will further increase access to specialty care for those patients suffering from these diseases. Additionally, we are conducting a project to help residents of poor, industrialized neighborhoods in Denver understand and reduce their exposures to hazardous air pollutants. These programs offer strategies to better serve all patients within our community.

**5. Evidence Base:**

- Agency for Healthcare Research and Quality, 2017. The CAHPS ambulatory care improvement guide: Strategies for improving patient experience with ambulatory care, 6.E. rapid referral programs. Rockville: AHRQ. Available at: <https://www.ahrq.gov/cahps/quality-improvement/improvement-guide/6-strategies-for-improving/access/strategy6g-rapid-referral.html>. (Last accessed 02/04/2021).
- Kripalani, S., Theobald, C.N., Anctil, B. & Vasilevskis, E.E., 2014. Reducing hospital readmission rates: current strategies and future directions. *Annual Review of Medicine*. 65, 471-85.

**6. Does Proposed Intervention Intersect with Ongoing Initiatives Statewide? If Yes, Identify:**

**7. Does Hospital or Affiliated Community Partner(s) Have Experience with Intervention and/or Core Population? If So, How Does the Experience Support the Success of the Intervention?**

National Jewish Health is a large provider of specialty care for the Medicaid population. A previous grant funded project implemented at National Jewish Health was a pilot three-year clinic for under-served and under-insured patients. Patient self-reported statistics demonstrated a 19% decrease in ED visits and a 23% decrease in pulmonary related hospitalizations during the course of this clinic. Coordinating the care for these patients improved patients’ appointment attendance which increased our ability to care for the patients ongoing needs. This program identified several strategies to better serve homeless and low-income patients which have been incorporated into clinics across the institution.

**8. Is This an Existing Interventions? If Yes, Explain:** No, new intervention.

**9. Will the Interventions Be a Joint Effort with Another Organization?** No.

### SW-BH2 – Pediatric Screening for Depression

Percent of pediatric patients 12 years or older who were screened for depression including suicide risk during an inpatient or emergency department encounter.

1. **Name of Intervention:** Implement standardized assessment for pediatric inpatient depression and suicide risk.

2. **Measure Selection:** SW-BH2

3. **Intervention Description and Rationale Including Target Population for the Intervention and How the Intervention Advances the Goals of the HTP:**

Depression is a leading cause of disability in the United States. Children are especially prone to impairments in school performance, poor interactions with their peers and are at an increased risk for suicide. Children with chronic medical conditions are known to experience depression at a higher rate than children without chronic medical conditions. In nationally representative U.S. surveys, about 8% of adolescents reported having major depression in the last year. 19% of adolescents aged 13 to 17.9 years with major depressive disorder attempt suicide. Members of the U.S. Preventive Services Task Force (USPSTF) found adequate evidence that screening instruments can accurately identify major depressive disorder in adolescents aged 12 to 18 years in primary care settings.

The rate of suicide is increasing in America and it is now the tenth leading cause of death. Colorado statistics indicate that suicide is more prevalent for youth in the 15-19 age range than in the younger age group. Suicide in males is more than twice that of females. Additional studies have shown that 29.5% of high school students indicate feeling sad or hopeless almost every day for two weeks or more in a row during the previous months. Patients with chronic health conditions are at risk for depression and suicide due to the complexities of their care. Medicaid patient have additional challenges in obtaining behavioral health services due to environmental and social issues that limit access to the care they need.

National Jewish Health does screen all inpatients  $\geq$  12 year of age for suicide risk using the ASQ screening tool. Patients who screen positive for suicide risk are evaluated by a licensed provider and follow-up interventions are determined and implemented. Since most of our pediatric inpatients have chronic health conditions, implementing a screening tool for depression would provide opportunities to intervene at the time of admission by determining the appropriate interventions to help address their behavioral needs and reduce harm.

4. **Describe How the Intervention and Selected Measure Align with Community Needs:**

The majority of our pediatric inpatients are Medicaid patients primarily from Denver county. Most of the patients suffer from severe asthma. Dealing with a chronic health disorder places many burdens on the patients and their families, increasing their risk for depression and harm which can lead to ER visits and hospitalizations.



**5. Evidence Base:**

- U.S. Preventive Services Task Force, 2016. Final recommendation statement: Screening for depression in children and adolescents: Screenings. Rockville: USPSTF. Available at: <https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/depression-in-children-and-adolescents-screening>. (Last accessed: 02/04/2021).
- Joint Commission, 2018. Suicide prevention resources to support Joint Commission accredited organizations implementation of NPSG 15.01.01.
- Horowitz, L.M., Bridge, J.A., Pao, M. & Boudreaux, E.D., 2014. Screening youth for suicide risk in medical settings: time to ask questions. *American Journal of Preventative Medicine*. 47(3 Suppl 2): S170-5.
- Adams, J.S., Chien, A.T., & Wisk, L.E., 2019. Mental illness among youth with chronic physical conditions. *Pediatrics*. 144 (1), 1-11.

**6. Does Proposed Intervention Intersect with Ongoing Initiatives Statewide? If Yes, Identify:**

Colorado Department of Public Health & Environment provides many resources and tools for youth and young adult suicide prevention.

**7. Does Hospital or Affiliated Community Partner(s) Have Experience with Intervention and/or Core Population? If So, How Does the Experience Support the Success of the Intervention?**

National Jewish Health supports an on-going pediatric psycho-social service that is experienced in addressing and treating the needs of patient and families with chronic illness and behavioral/emotional needs.

**8. Is This an Existing Interventions? If Yes, Explain:** No, new intervention.**9. Will the Interventions Be a Joint Effort with Another Organization?** No.**SW-COE1 – Hospital Index**

A measure of avoidable care across procedural episodes. A hospital's index score will be compared to a baseline index score.

- 1. Name of Intervention:** Create a standard approach to monitor potentially avoidable complications for Colonoscopy and EGD and continuous improvement
- 2. Measure Selection:** SW-COE1
- 3. Intervention Description and Rationale Including Target Population for the Intervention and How the Intervention Advances the Goals of the HTP:**

This intervention addresses potentially avoidable costs of care for the Medicaid population. By utilizing the PROMETHEUS Analytics tool, we can utilize claims data to analyze episodes of care and examine opportunities to improve care and efficiency. National Jewish Health performs a large number of colonoscopies and esophagogastroduodenoscopies (EGD) in our Minimally Invasive Diagnostic Center (MIDC). These are ambulatory procedures with patients discharged home the same day. Many deaths related to colorectal cancer can be prevented by getting early, regular screenings such as a colonoscopy. An EGD is done to evaluate a number of digestive disorders such as reflux, heartburn, swallowing difficulties and abdominal pain. These problems have been associated with respiratory issues such as airway obstruction, aspiration, asthma, chronic cough and bronchospasm.

Colonoscopy is the most commonly performed endoscopic procedure and is considered low risk. However, adverse events such as bleeding and perforation can occur which can lead to ER visits and unplanned hospitalizations. Studies have found an increase in serious adverse events in the patient population due to the presence of comorbid conditions such as diabetes, stroke, atrial fibrillation and congestive heart failure. By reviewing opportunities to decrease potentially avoidable complications, this will allow us to identify opportunities in our pre-assessment process, patient risk identification, and patient education.

**4. Describe How the Intervention and Selected Measure Align with Community Needs:**

At National Health, Patients have their outpatient procedure and are discharged same day. Our nursing team conducts a telephone follow-up, the next day or day after, to determine if the patient is back to normal or experiencing procedure related issues which could lead to ER and hospital admissions. Reducing complications from colonoscopies and EGD procedures will decrease ER or associated hospitalizations from these procedures.

**5. Evidence Base:**

- Schiller, L.R., 1996. Upper gastrointestinal motility disorders and respiratory symptoms. *American Journal of Health-System Pharmacy*. 15, 53(22 Suppl 3):S13-6.
- Kothari, S.T., Huang, R.J., Shaukat, A., *et al.*, 2019. ASGE review of adverse events in colonoscopy. *ASGE*. 90 (6), 863-876.

**6. Does Proposed Intervention Intersect with Ongoing Initiatives Statewide? If Yes, Identify:**

**7. Does Hospital or Affiliated Community Partner(s) Have Experience with Intervention and/or Core Population? If So, How Does the Experience Support the Success of the Intervention?**

National Jewish Health currently monitors multiple attributes of procedure care, including complications. Opportunities for improvement in preventing complications are implemented when identified.

**8. Is This an Existing Interventions? If Yes, Explain:**

We will continue to monitor all procedure related complications to assess for improvement opportunities.

**9. Will the Interventions Be a Joint Effort with Another Organization? No.**

**COE1 – Transmission of Summary of Care Record**

Successful transmission of a summary of care record, as described in the intervention, to a Medicaid patient's PCP or other healthcare professional within one business day of discharge from an inpatient facility to home.

**1. Name of Intervention:** Increase successful transmission of a summary of care record to patient's PCP

**2. Measure Selection:** COE1

**3. Intervention Description and Rationale Including Target Population for the Intervention and How the Intervention Advances the Goals of the HTP:**

This intervention will address the process for a successful transmission of the summary of care from National Jewish Health to the patient's PCP or other healthcare professional. Providing a summary of care, after an inpatient or observation admission, can address on-going and follow-up care issues that impact the patient's health. NJH has selected COE1 measure for coordinating follow-up care in an effort to drive down rates of hospital re-admissions.

**4. Describe How the Intervention and Selected Measure Align with Community Needs:**

According to the Center for Healthcare Research and Transmission, poorly coordinated care transitions from hospital to other care settings cost an estimated \$12 billion to \$44 billion annually. Poor transitions often result in poor health outcomes and adverse events such as medication errors, procedure complications, infections and falls.

Best practices on care transitions from hospital to home include these elements:

- Comprehensive discharge planning
- Complete and timely communication of information
- Medication reconciliation
- "Teach back" method of patient/care giver education
- Open communication between providers
- Prompt and timely follow-up with an outpatient provider post discharge

Research suggests that following these practices will create the foundations for effective, high-quality and cost-saving care for patients after a hospitalization.

**5. Evidence Base:**

- Alper, E., O'Malley, T.A. & Greenwald, J., 2020. Hospital discharge and readmission. Available at: [https://www.uptodate.com/contents/hospital-discharge-and-readmission?search=telemedicine&source=search\\_result&selectedTitle=3~34&usage\\_type=default&display\\_rank=3](https://www.uptodate.com/contents/hospital-discharge-and-readmission?search=telemedicine&source=search_result&selectedTitle=3~34&usage_type=default&display_rank=3). (Last accessed: 02/04/2021).
- Center for Healthcare Research & Transformation, 2014. Care Transitions: Best Practices and Evidence-based Programs. Available at: <https://chrt.sites.uofmhosting.net/wp-content/uploads/2014/01/CHRT-Care-Transitions-Best-Practices-and-Evidence-based-Programs-.pdf>. (Last accessed: 02/04/2021).

**6. Does Proposed Intervention Intersect with Ongoing Initiatives Statewide? If Yes, Identify:**

**7. Does Hospital or Affiliated Community Partner(s) Have Experience with Intervention and/or Core Population? If So, How Does the Experience Support the Success of the Intervention?**

No.

**8. Is This an Existing Interventions? If Yes, Explain:** No, new intervention.

**9. Will the Interventions Be a Joint Effort with Another Organization?**

We will be working with Colorado Access for transition of care summary to the RAE and primary care provider for all inpatients. Our goal is to create a program that focuses on best practices for care transitions.

### COE3 – Implementation/Expansion of E-Consults

The annual number of e-Consults supported through the hospital.

- 1. Name of Intervention:** Implementation/expansion of e-consults
- 2. Measure Selection:** COE3
- 3. Intervention Description and Rationale Including Target Population for the Intervention and How the Intervention Advances the Goals of the HTP:**
- 4. Describe How the Intervention and Selected Measure Align with Community Needs:**

E-consults are defined as asynchronous, consultative provider-to-provider communication using a web based or telephonic platform. E-consults are intended to improve access to specialty expertise for patients and providers without the need for face-to-face visits. The use of e-consults can have the potential of not only improving access and timeliness to specialty care but can reduce in-person costs associated with specialty visits. In a VA report, e-consults reduced consultation response time by 92 – 95% in 3 of 5 specialties. Reports of increased patient and provider satisfaction were also noted.

Our Healthcare providers survey also expressed an interest in better access to National Jewish Health expertise through e-consults with National Jewish Health faculty. By expanding our capabilities for e-consults, we can share our expertise with other providers caring for patients with respiratory diseases. This could result in better patient health outcomes, reduce patient costs and implement a more collaborative approach for diagnosis and treatment.

**5. Evidence Base:**

- Velden, T., Schalk, B.W.M., Harmsen, M., *et al.*, 2019. Implementation of web-based hospital specialist consultations to improve the quality and expediency of general practitioners' care. *Fam Practice*. 20 (1), 73.
- Vimalananda, V.G., Gupte, G., Seraj, S.M., *et al.*, 2015. Electronic consultations (e-consults) to improve access to specialty care: a systematic review and narrative synthesis. *Journal of Telemed Telecare*. 21 (6), 323-30.
- Liddy, C., Drosinis, P., Keely, E., 2016. Electronic consultation systems worldwide prevalence and their impact on patient care. *Fam Practice*. 33 (3), 274-85.

**6. Does Proposed Intervention Intersect with Ongoing Initiatives Statewide? If Yes, Identify:**

**7. Does Hospital or Affiliated Community Partner(s) Have Experience with Intervention and/or Core Population? If So, How Does the Experience Support the Success of the Intervention?**

National Jewish Health developed a robust structure for offering telehealth visits when the COVID-19 pandemic started and continues to conduct a meaningful percentage of encounters through telehealth. The Infectious Disease service has offered a-consult service for a number of years targeting clinicians from all over the country seeking advice on the best practices for treating mycobacterial respiratory infections. Using these examples, we hope to expand our e-consult services for treating other respiratory diseases.

**8. Is This an Existing Interventions? If Yes, Explain:** No, new intervention.

**9. Will the Interventions Be a Joint Effort with Another Organization?**

We will be working with Pinnacle for implementation and expansion of e-consults.