What is ACCORDS?

Adult and Child Center for Outcomes Research and Delivery Science

ACCORDS is a ‘one-stop shop’ for pragmatic research:

- A multi-disciplinary, collaborative research environment to catalyze innovative and impactful research
- Strong methodological cores and programs, led by national experts
- Consultations & team-building for grant proposals
- Mentorship, training & support for junior faculty
- Extensive educational offerings, both locally and nationally

ACCORDS Upcoming Events – mark your calendars!

April 4, 2025 11am-1pm Krugman Conference Hall	**ACCORDS & CCTSI Community Engagement Showcase** *Connect with community and academic partners!*
April 30 + May 1, 2025 9am-3pm MT Zoom	**Strengthening the Application of Theories, Models, and Frameworks in Implementation Research** *Back by popular demand! Registration is now live!*
May 12, 2025 12-1pm MT AHSB Room 2200/2201	**Emerging Topics in Digital Health & Clinical Informatics** *Real World Augmented Supportive Care: Tech to Touch* Presented by: Matt Loscalzo, MSW
Annual Conference June 4-5, 2025 9-4pm MT	**Colorado Pragmatic Research in Health Conference** Future of Pragmatic Research: Team Science to Enhance Innovation and Impact *Registration now open → Visit COPRHcon.com for more information!*

Learning Health Systems: *Perspectives from a Health System Executive*

Presented by:
Jean S. Kutner, MD, MSPH
Chief Academic Officer, UCHealth
Distinguished Professor, CU School of Medicine

Learning Health Systems: Perspectives from a health system leader

Jean S. Kutner, MD, MSPH
Chief Medical Officer, University of Colorado Hospital
Chief Academic Officer, UCHealth
Distinguished Professor, University of Colorado School of Medicine

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Outline

- About UCHealth
- UCHealth current priorities
- Examples: initiatives and results
- UCHealth Quality and Research Administration resources
- Envisioned future

About UCHealth

Mission
We improve lives. In big ways through learning, healing and discovery. In small, personal ways through human connection. But in all ways, we improve lives.

Vision
From health care to health.

Values
Patients first
Integrity
Excellence

Who we are
and
how we do it.

Values in Action

- We **take care** of others by taking care of ourselves first.
- We always **prioritize safety**.
- We **connect** with compassion and respect.
- We **act inclusively,** so those with diverse ideas and perspectives are supported.
- We **speak up** when there's an opportunity to make things better.
- We provide extraordinary care and service by **being accountable** for our actions.
- We **strive for excellence** in our work, and when we fall short, we learn and improve.

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About UCHealth

14
Hospitals

4 Northern Colorado
4 Metro Denver
6 Southern Colorado

More than
2.5K
Available beds

Hospital beds:
579 Northern Colorado
989 Metro Denver
852 Southern Colorado


Poudre Valley Hospital
Fort Collins


Medical Center of the Rockies
Loveland


Greeley Hospital
Greeley


Longs Peak Hospital
Longmont


Broomfield Hospital
Metro Denver


University of Colorado Hospital
Metro Denver


Highlands Ranch Hospital
Metro Denver


Memorial Hospital North
Colorado Springs


Grandview Hospital
Colorado Springs


Memorial Hospital
Colorado Springs


Pikes Peak Regional Hospital
Woodland Park


Yampa Valley Medical Center
Steamboat Springs


Parkview Medical Center
Pueblo


Parkview Pueblo West Hospital
Pueblo

More than

35K employees

124K surgeries

2.7M unique patients

8.7M outpatient, urgent care and emergency room visits

16K babies delivered

7K affiliated or employed providers

973 new patients per day

187K inpatient admissions and observation visits

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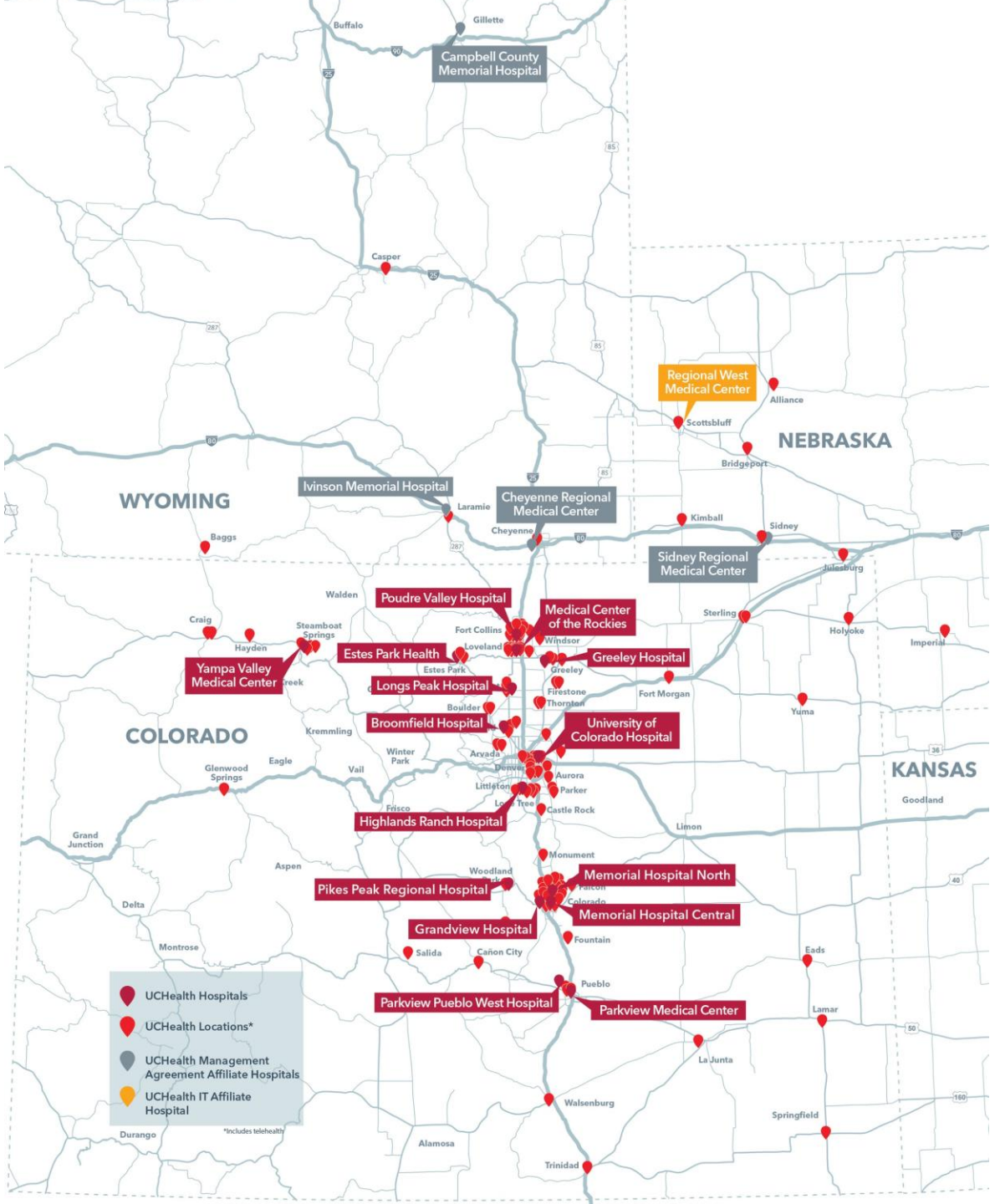
UCHealth reach extends throughout the Rocky Mountain region.



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UCHealth is recognized as a leader in quality.

#1 in CO: University of Colorado Hospital
#2 in CO: Medical Center of the Rockies
#4 in CO: Memorial Hospital

The only organization to achieve back-to-back #1 overall quality ranking from the University Health System Consortium

2024 U.S. News National Specialties Rankings:
University of Colorado Hospital: Four specialties ranked.

HEALTH CARE'S MOST WIRED ADVANCED
(1 OUT OF 27 NATIONALLY)

TOP 10
IN QUALITY
PERFORMANCE

2008 Baldridge National Quality Award, the nation's highest honor for innovation and performance excellence

Magnet Designation, American Nurses Credentialing Center

Medical Center of the Rockies, Poudre Valley Hospital, Memorial Hospital Central, Memorial Hospital North and University of Colorado Hospital have all been awarded multiple Magnet designations for nursing excellence.

- Lown Institute: Nation's No. 2 Most Socially Responsible Health System
- ANCC Magnet Recognition Program®
- The Best and Brightest Companies to Work For
- Certified Great Place to Work
- CHIME® Level 10 Most Wired Recognition
- HIMSS Stage 7 Certification
- Top Workplaces by The Denver Post

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The value of academic medicine extends beyond just teaching and research.

Physician and provider training

Approximately **45%** of all Colorado physicians were trained in our institutions; other training programs include pharmacy, nursing and dentistry.

Advanced treatments for patient clinical trials

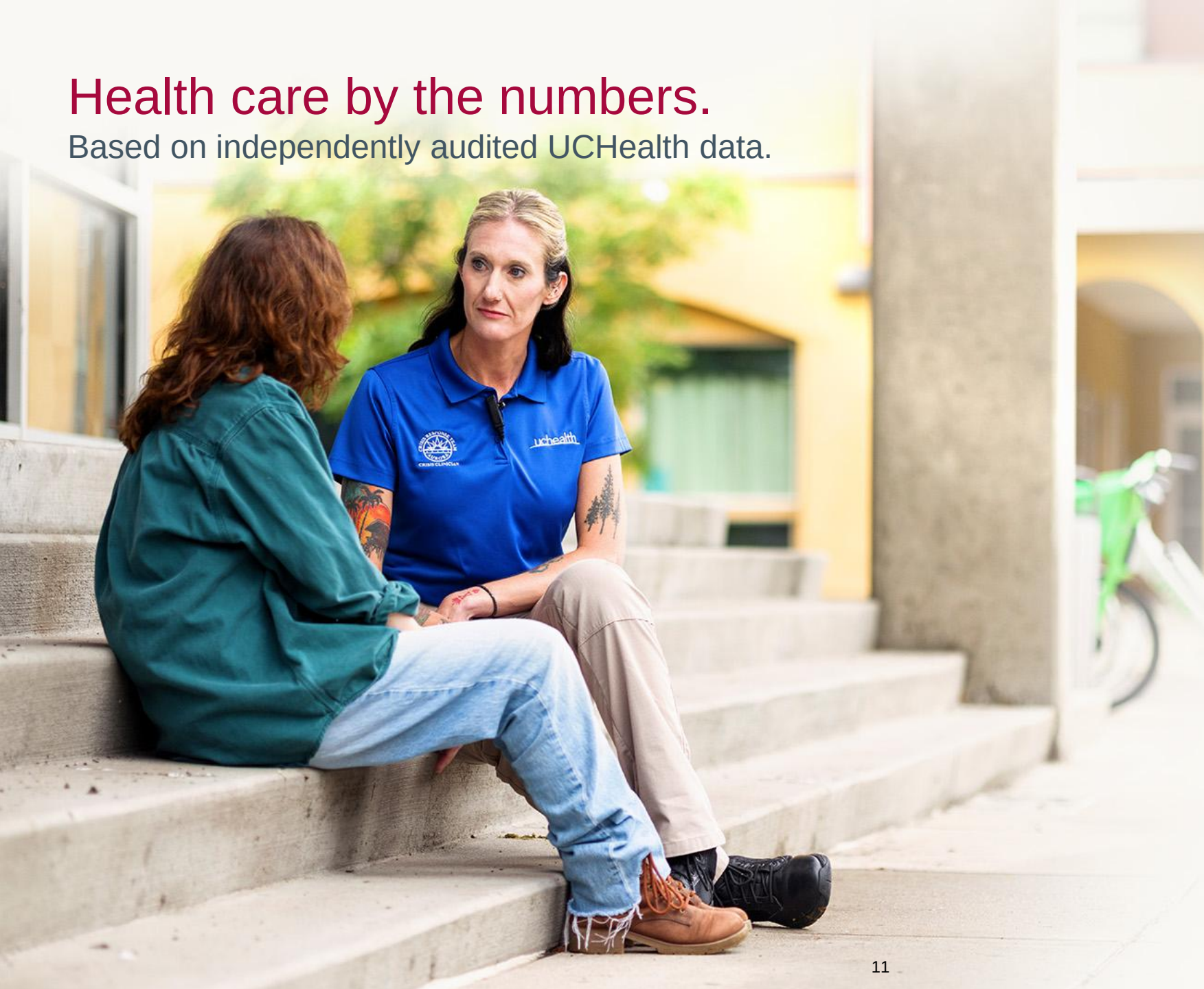
In partnership with the University of Colorado Anschutz Medical Campus, UCHealth provides more than **1,700** clinical trials and **1,200** active research projects in the community setting.

Research and innovation

The only academic medical center in Colorado with more than **$700M** in total research funding, UCHealth provided more than **$315M** to CU to support its academic and research enterprise, 10 times more than state funding.

Health care by the numbers.

Based on independently audited UCHealth data.



$580M

in uncompensated care

$1.2B

in total community benefit

UCHealth's community benefits are

3x greater

than the value of its tax exemption, valued at $357 million

$11.6B

in total economic impact for Colorado

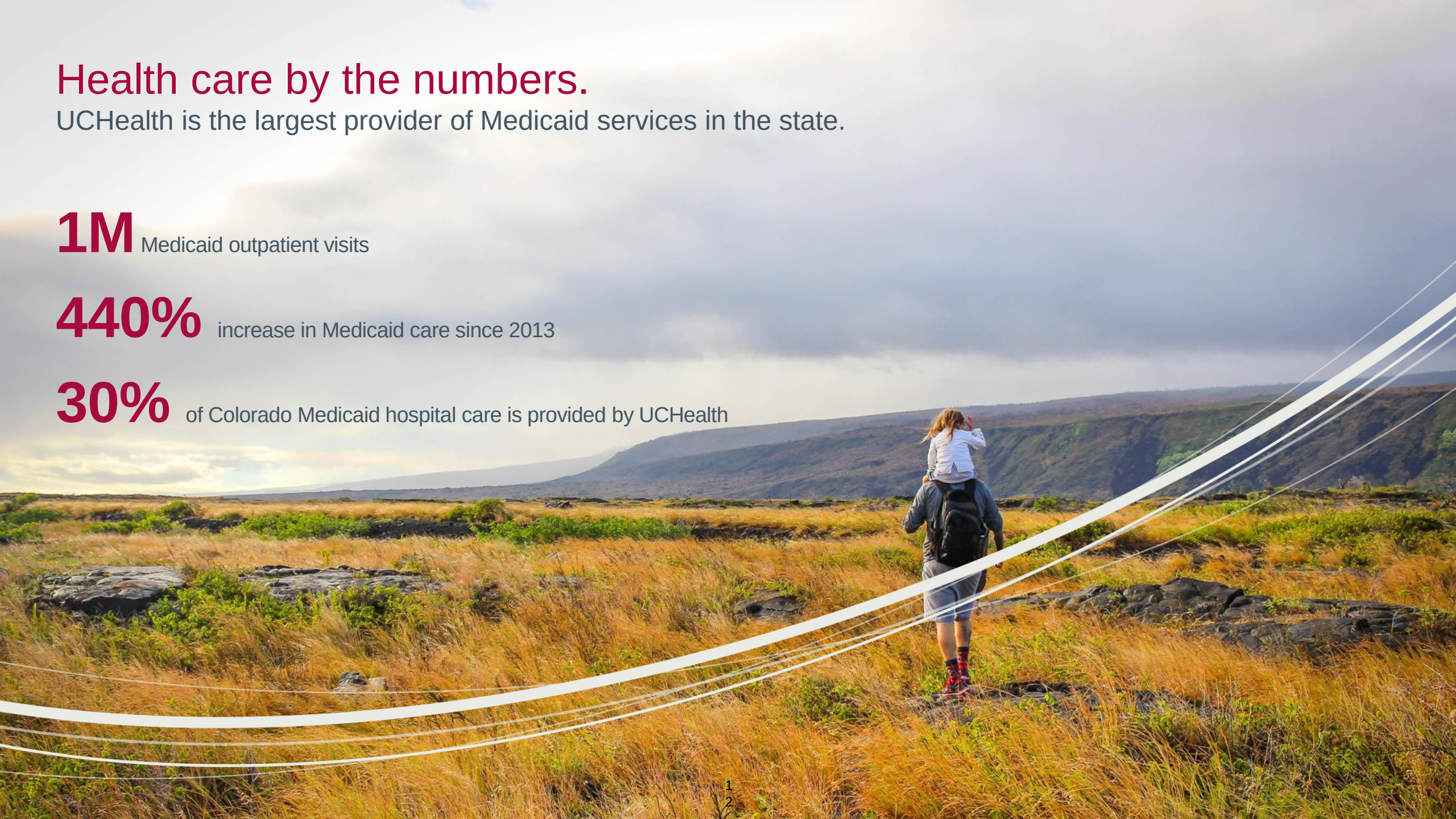
Health care by the numbers.

UCHealth is the largest provider of Medicaid services in the state.

1M Medicaid outpatient visits

440% increase in Medicaid care since 2013

30% of Colorado Medicaid hospital care is provided by UCHealth



UCHealth: High Reliability

Patients

Experience excellence every time.

Front-line team members

Experience alignment between vision, culture, and process.
Have clear priorities and expectations.
Can complete their work without unnecessary complexity.

Leaders

Create predictable systems.

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UCHealth: High Reliability Care Delivery

	Start of Episode	During the Episode	End of Episode
	Patient knows what to expect during their stay. • In-clinic pathway initiation • Patient onboarding • Nurse leader rounding on new admits	Patient feels safe and their needs are met. Care is consistent – every patient, every time. • Evidence-based clinical pathways to drive care • Purposeful hourly rounding at bedside • Patient responsiveness tactics for clinical support service areas (e.g. therapies, RT, EVS, etc)	Patient feels prepared for next level of care. • Medication teaching day prior to discharge • Discharge experience • Follow-up care coordination
	Team has the tools and reliable support to on-board patients. • Virtual RN workflows to enhance admit process • Enhanced team member onboarding	Team workflow supports the consistent ability to proactively address patient needs. Clinical teams can focus on clinical care. • Simplify the lives of our clinical teams (e.g. supply chain, HR, pharmacy, service recovery support) • Scale best practice solutions • Huddles to monitor quality outcomes and needs (q4) • Leadership rounding	Team has the tools and reliable support to discharge patients. • Virtual RN workflows to enhance discharge process • Ease of ambulatory access for follow-up visit coordination

Culture and Cohesion

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FY25 UCHealth Quality and Safety Priorities

Measure	FY25 Q1	FY25 Q2	FY25 Q3	FY25 Q4	FY26 Q1
Responsiveness	Plan / Do	Study / Act	Review/ Revise / Sustain		
Mobility		Plan / Do	Study / Act	Review/ Revise / Sustain	
Peri-procedural Safety			Plan / Do	Study / Act	Review/ Revise / Sustain
Readmissions and Excess Days				Plan / Do	Study / Act

Other Ongoing UCHealth Priorities	
Mortality	Review/ Revise/ Sustain (GIP Hospice, deterioration work, service line focused work, reviews)
Hospital Acquired Pressure Injuries (HAPI)	Local focus; Align with mobility/turning

University of Colorado Hospital

FY25 Quality and Safety Goals & Expectations

Responsiveness	Mobility (Falls and HAPI)	Surgical/ Procedural Safety	Readmissions and Excess Days	Mortality
FY25 Q1	**FY25 Q2**	**FY25 Q3**	**FY25 Q4**	**Ongoing**
Goal/ Expectation: • Participation in "set, meet, own" framework • Introduce yourself by name and role to patients upon entering the room in all care settings • Ask "is there anything else I can do for you before I leave" and be responsive to needs	**Goal/ Expectation:** • Review mobility goal and mobility goal achievement during bedside rounds • Ensure activity orders are reflective of patient status • Order therapy consult as applicable • Reinforce mobility expectations with patient both in clinic and inpatient	**Goal/ Expectation:** • Complete Brief Op Note for all surgical/ procedural departments • Implement best practice bundles to reduce post-operative respiratory failure and post-operative sepsis • Follow Enhanced Recovery After Surgery (ERAS) bundles to reduce Surgical Site Infections (SSIs) • Follow surgical and procedural safety bundle including time-out and debriefs	**Goal/ Expectation:** • Ensure patients have a follow-up appointment (primary or specialty care) scheduled before discharge • Create ambulatory access for discharged patients and high-risk individuals to avoid readmissions and unnecessary ED visits	**Goal/ Expectation:** • Identify and respond to deterioration • Optimize medical and surgical perioperative management • Connect patient and family with Hospice services when aligned with goals of care • Respond to CDI queries to capture acuity and appropriate documentation

Examples

Artificial Intelligence Facilitated Virtual Surveillance Model Associated with Reduced In-Hospital Mortality

Hemali Patel MD, Angela Keniston PhD MSPH, Amy Hassell RN MSN, Brittany Cyriacks RN MSN CMSRN, Drew Brendan, Alexander Lincoln, Sarah Mann MA, Richard Zane MD, Christine D. Jones MD MSc

Background

- Inpatient clinical deterioration is associated with higher rates of morbidity and mortality.
- Timely identification and treatment of clinical deterioration is logistically complex yet critical to improve clinical outcomes.
- Real-time telemetry, pulse oximetry, and capnography data has the potential to identify real-time clinical deterioration

Goal

- Evaluate impact of embedding artificial intelligence (AI) tools in the electronic health record (EHR) to promote timely identification and intervention for clinical deterioration.
- Evaluate clinical outcomes with baseline AI tools compared to AI tools after the addition of telemetry trigger.

Methods

Baseline AI Tools and Process:

- AI tools embedded in EHR for 12 UCHealth hospitals, ~1800 medical/surgical and progressive care beds included:
  - Shock index, Epic Deterioration Index, Epic Sepsis Predictive Model and Respiratory Distress Index
- When AI tool thresholds are met, a clinical deterioration alert is sent to a central telemedicine command center (VHC) where intensive care trained nurses (vICU RN) complete chart review.
- If rapid response criteria are met, the vICU RN discusses with bedside team on whether a bedside RRT was warranted

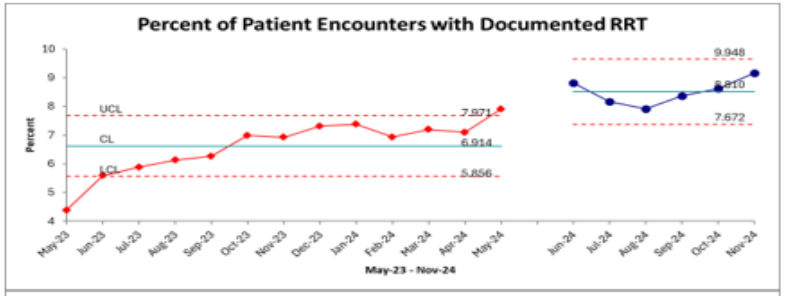
AI tools with addition of telemetry trigger:

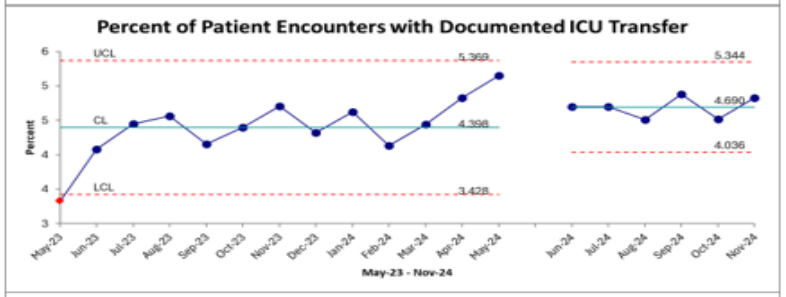
- AI tool embedded in EHR to include real-time telemetry, pulse oximetry and capnography data.
- If data alerted at least 3 times in an hour to bedside nurse, an alert also sent to vICU RN for review
- vICU RN calls an RRT from the VHC when patients meet criteria to evaluate patient in real-time rather than first discussing with bedside team

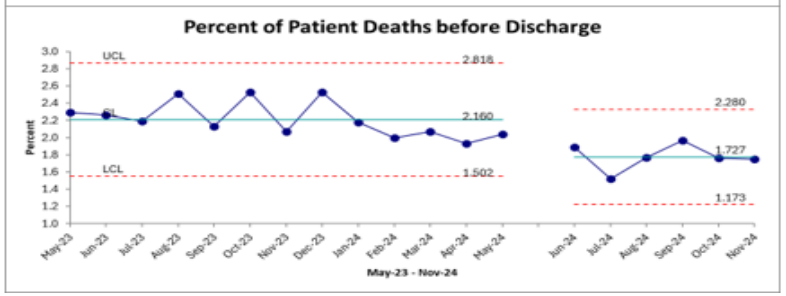
Methods

•Completed a limited time series, uncontrolled pre-post study design to compare patient outcomes.
•Included adults 18 years of age or older discharged from medicine, subspecialty, surgery, orthopedic services after an observation or inpatient admission.
•Pre-intervention: May 23, 2023 – May 27, 2024
•Post-intervention: May 28, 2024 – November 30, 2024

Results







Results

Outcome N (%)	Pre-intervention patient encounters N = 124,142	Post-intervention patient encounters N = 66,357	P-value
AI tool trigger	59,197 (48)	32,566 (49)	
Telemetry trigger	0 (0)	4,894 (7)	
RRT	8,557 (7)	5,865 (9)	<.0001
ICU transfer	5,449 (4)	3,125 (5)	0.0013
Death before discharge	2,681 (2.2)	1,155 (1.7)	<.0001

Conclusion

•AI tools, paired with nurse clinical adjudication, can help identify clinical deterioration more quickly than bedside team assessments.
•Adding real-time telemetry, pulse oximetry and capnography data identified additional real-time cases with clinical deterioration.
•Formalizing calling RRTs when patients first meet criteria, rather than relying on bedside teams, was associated with:
•Higher proportion of RRTs and transfers to higher level of care,
•Lower in-hospital mortality.

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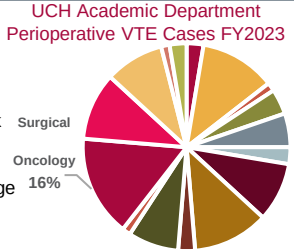
Multidisciplinary Quality Improvement Initiative to Reduce Rates of Perioperative Venous Thromboembolism in Surgical Oncology Patients

Durden J, Klauck P, Abud V, Knott L, Berg S, Robbins E, Ballou M, Anoff D, Trujillo T, Thompson E, Hassel K, Wohlauer M, Mungo B, Del Chiaro M, Tevis S, Brainard J.

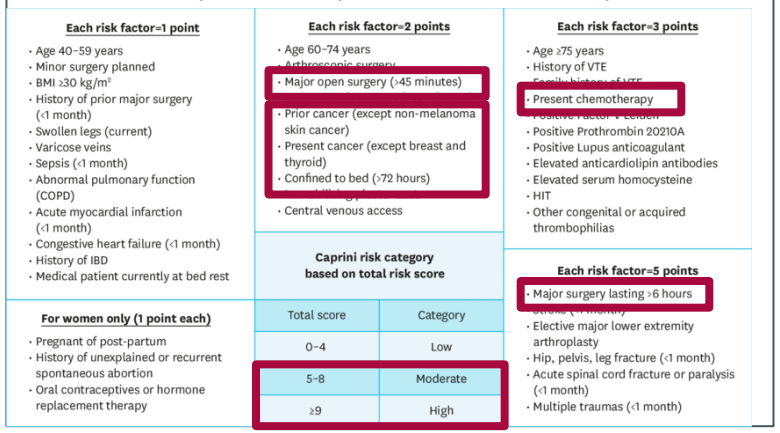
UC Health University of Colorado Hospital
Department of Surgical Oncology
Department of Anesthesia/Critical Care

Background

- Perioperative venous thromboembolism (VTE) is a morbid and costly complication for patients and health systems (mortality, length of stay, etc.)
- Surgical oncology patients are at the highest risk of VTE based on a confluence of myriad risk factors
- Surgical oncology comprised a greater percentage of VTE incidence than any other surgical service line in FY2023



Caprini Score (VTE Risk Stratification)



https://www.researchgate.net/figure/Caprini-risk-assessment-model-Caprini-score-of-10-or-greater-are-considered-high-risk_fig1_338173232

Purpose

To determine the optimal parameters for administration of chemoprophylaxis and uniformly implement new "gold standard" guidelines throughout the surgical oncology service line to reduce rates of perioperative venous thromboembolism.

Method

- A multidisciplinary, multispecialty VTE prophylaxis guideline expert panel was assembled, including surgeons, anesthesiologists, hematologists, and pharmacists.
- Guideline development included review of national societal guidelines, clinical trials and meta-analyses
- Low molecular weight heparin (LMWH) was chosen as the first line agent due to efficacy, safety, lower risk of heparin-induced thrombocytopenia, and once-daily dosing. Timing of transition from unfractionated heparin to LMWH selected with surgeon buy-in.
- Incidence of VTE was chosen as primary outcome measure, with incidence of postoperative hemorrhage chosen as a balancing measure

Defined Gold Standard
1) Preop VTE PPX
2) 1st Dose Post-Op VTE PPX Within 8hrs
3) LMWH 1st Line

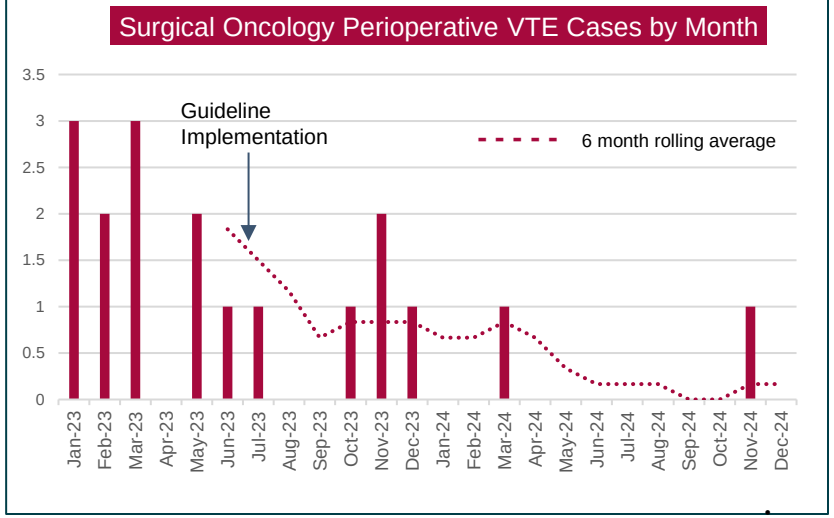
→

Assessed Retrospective Compliance
1) 13/14 (93%) received Pre-Op VTE PPX
2) 0/14 (0%) received Post-Op VTE PPX Within 8hrs
3) 0/14 (0%) received LMWH

→

Implementation and Standardization
1) Support & Promotion from Departmental Leadership
2) Communication & Education for Care Teams

Results



Implications

Implementing "gold-standard" guidelines led to a robust decrease in VTE cases in a perioperative surgical population.

There was no increase in post-operative hemorrhage rates

There were no changes in clinical documentation integrity

This represents a true improvement in patient care

The initiative is being spread to other surgical service lines with the same goal of reducing incidence of perioperative VTE.

- In a recent historical national cohort of inflammatory bowel disease patients undergoing major abdominopelvic surgery, **perioperative VTE was found to significantly increase:**
- Median **length of stay** (17.6 vs 6.7 days; $p < 0.001$)
- **Inpatient mortality** (5.0% vs 1.1%; OR 4.7, SE 3.2-7.0; $p < 0.001$).
- The **additional cost** associated with each inpatient venous thromboembolism was **$31,551** (95% CI, $29,136-$33,965).
- Comparable impacts are hypothesized in a surgical oncology population

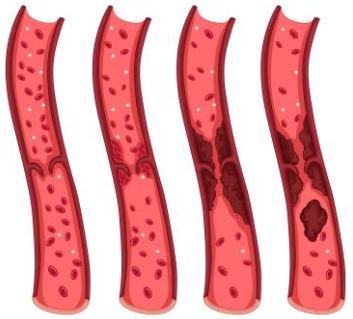


Image courtesy of *graphicsrf*, accessed on Vecteezy.com

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Improvements in Reducing Door-to-Needle Times and Obtaining an Accurate Weight for Acute Stroke Thrombolysis in the UCH ED

Stephanie Cox MS APRN AGCNS-BC, Heather Bina BSN RN SCRN MSC, Brandy Ravare BSN RN SCRN, Kerri Jeppson BSN RN SCRN ACS-BC and Sharon Poisson MD MAS

UCHealth Metro

UCH Stroke Program & Emergency Department

February 2025

Background & Stroke Facts

[1,2]

- National guidelines recommend thrombolysis for acute ischemic stroke in less than 30 minutes for > 50% of patients of their Emergency Department arrival to improve their outcomes[2]
- In calendar year 2023, we administered thrombolytics within 30 minutes only 18.5% of the time (as per our GWTG/ Get With The Guidelines® data registry) and lacked a standardized method to obtain an accurate weight in the ED for this weight-based drug

Purpose

The purpose of this quality improvement project was to improve the percentage of patients receiving thrombolysis in 30 minutes *(door-to-needle/DTN)* and monitor the accuracy of Tenecteplase® dosing based on patient weight within the ED via the new scale

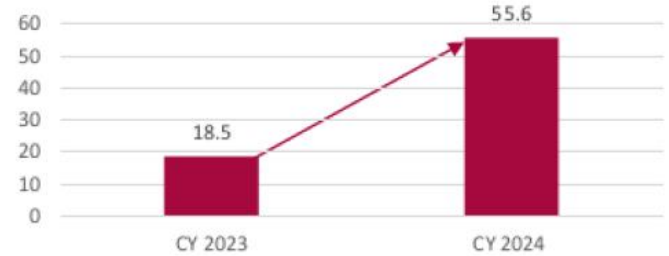
Method

- Population: UCH Emergency Department Acute Ischemic Stroke patients that received IV Tenecteplase® (TNK) during 2024
- Through chart abstraction & review DTN was calculated, and ED weights were compared to subsequent unit weights and tracked for accuracy according to TNK dosing guidelines; weights considered accurate if ED scale was used or chart review demonstrated an accurate weight based on charting

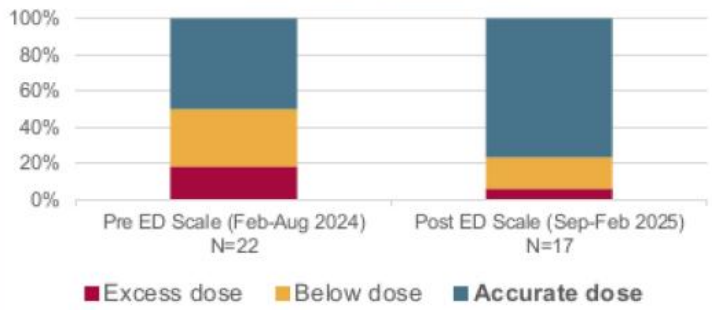
Results

- Using quality improvement techniques, we streamlined the communication and decision-making process in an ED stroke alert and implemented a new scale outside the Emergency Department CT scanners through the support of ED Leadership
  - Improved percentage of patients receiving thrombolysis in 30 minutes to **55.6%** for the year
  - Improved accuracy of TNK dosing by providing a process for an accurate weight for the time period after scale installation

% Patients DTN ≤ 30 minutes as per GWTG Data



Accuracy of TNK Dose (*per weight-based guidelines*) Pre and Post ED Scale Install



Implications

- Earlier treatment improves chance of recovery for acute ischemic stroke thrombolytic patients [1,2,4]
- Studies have demonstrated that a 30-minute delay in treatment leads to 10% decrease in functional outcome at 90 days [3,4]
- DTN < 30 minutes is associated with reduced length of stay[3]
- Faster DTN for patients also undergoing mechanical thrombectomy in Interventional Radiology is associated with more time at home (a meaningful patient outcome) & reduced mortality[4]
- American Heart Association's Target Stroke III initiative in 2019 sets a standard for thrombolysis in more than half of thrombolytic patients within 30 minutes. These improvements demonstrate safe and evidenced-based care for the acute ischemic stroke patient at UCH
- Obtaining an accurate weight via scale is achievable without delaying treatment[5]
- Opportunities for additional improvements include refinement of communications in the TNK huddle process and our Stroke Alert Epic secure chat & communication process

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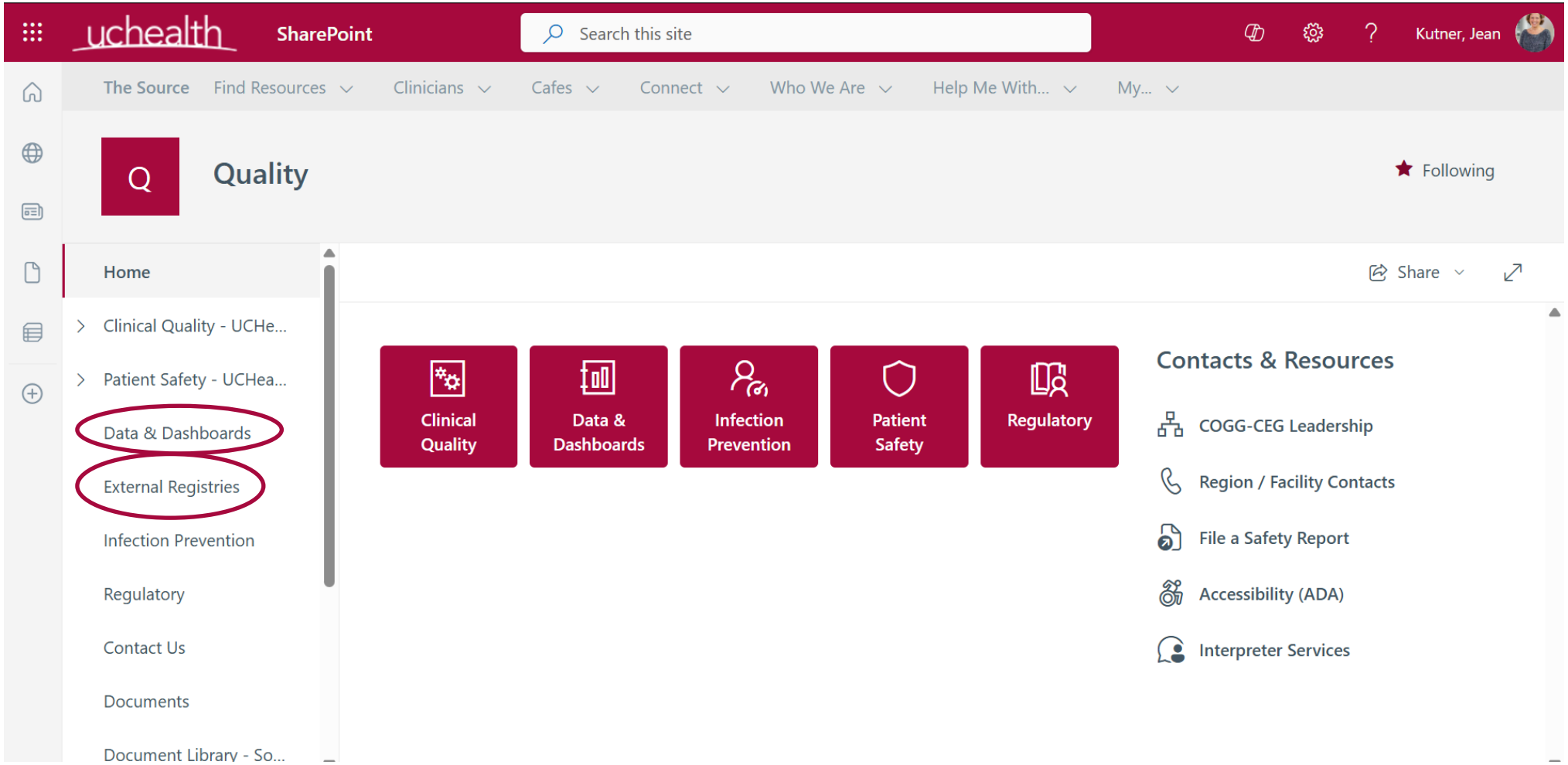
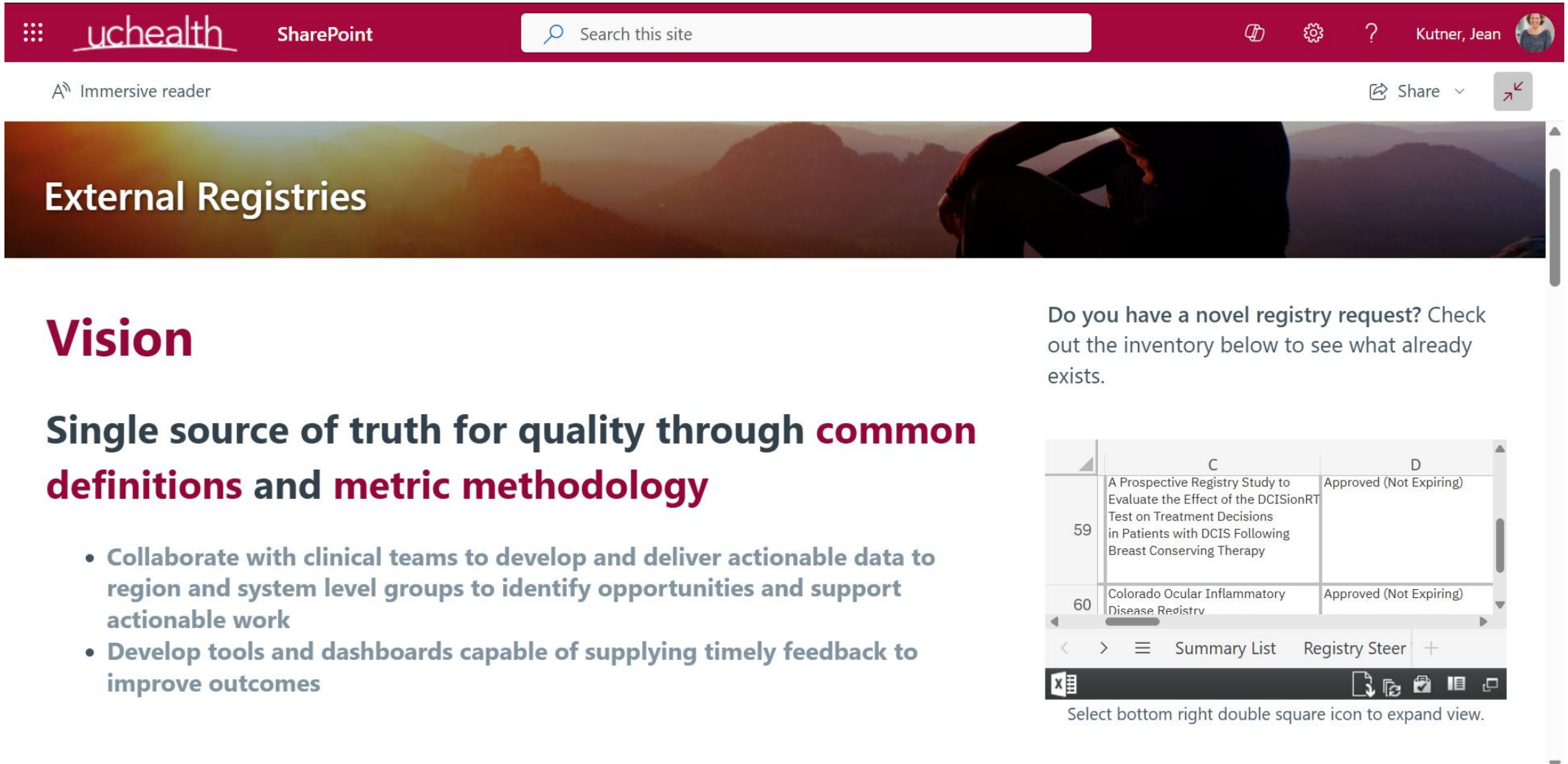
Resources: UCHealth Quality site on The Source

(accessible with cuanschutz or uchealth identities)



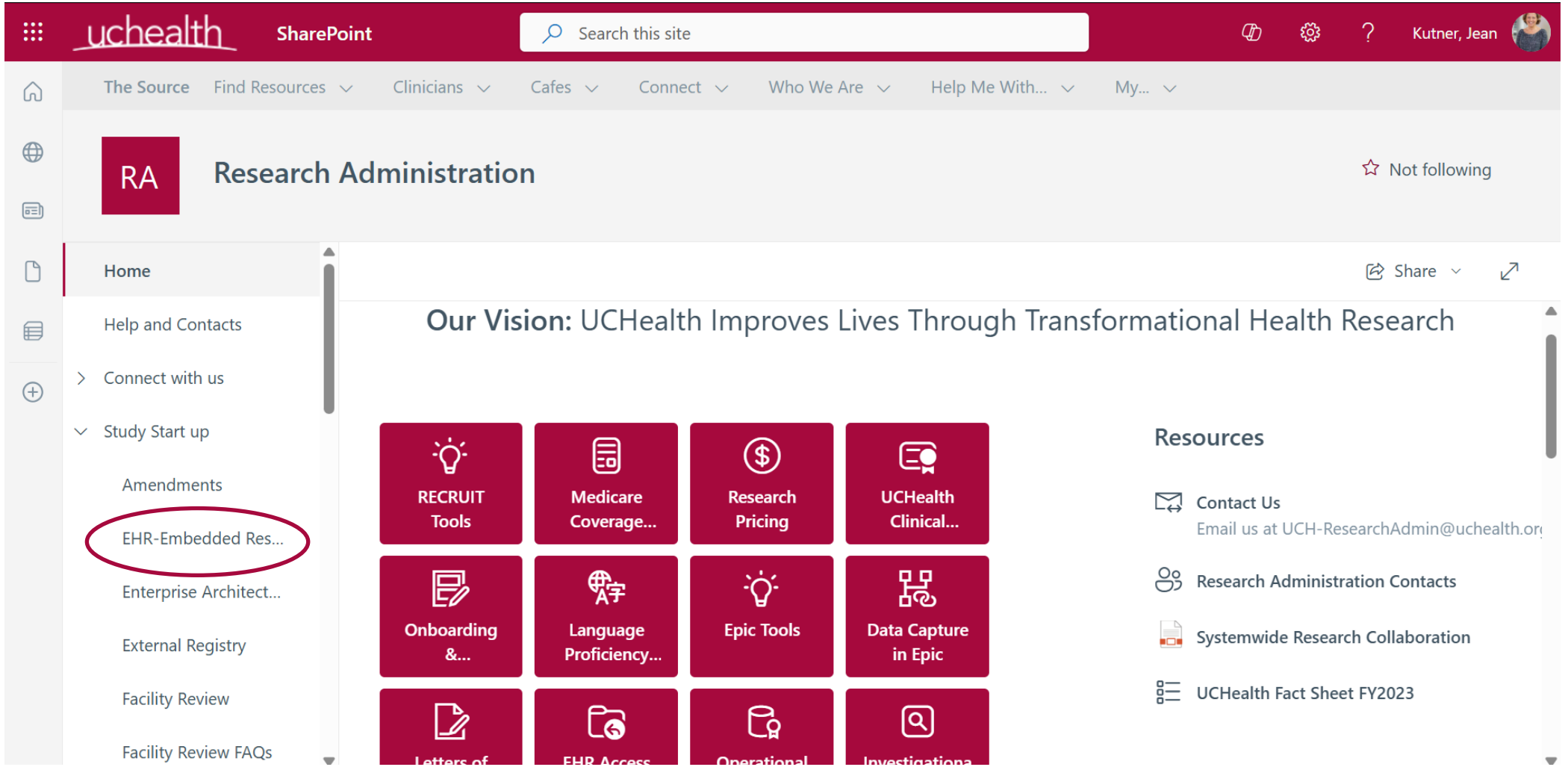
Resources: UCHealth Quality site on The Source

(accessible with cuanschutz or uchealth identities)



Resources: UCHealth Research Administration site on The Source

(accessible with cuanschutz or uchealth identities)



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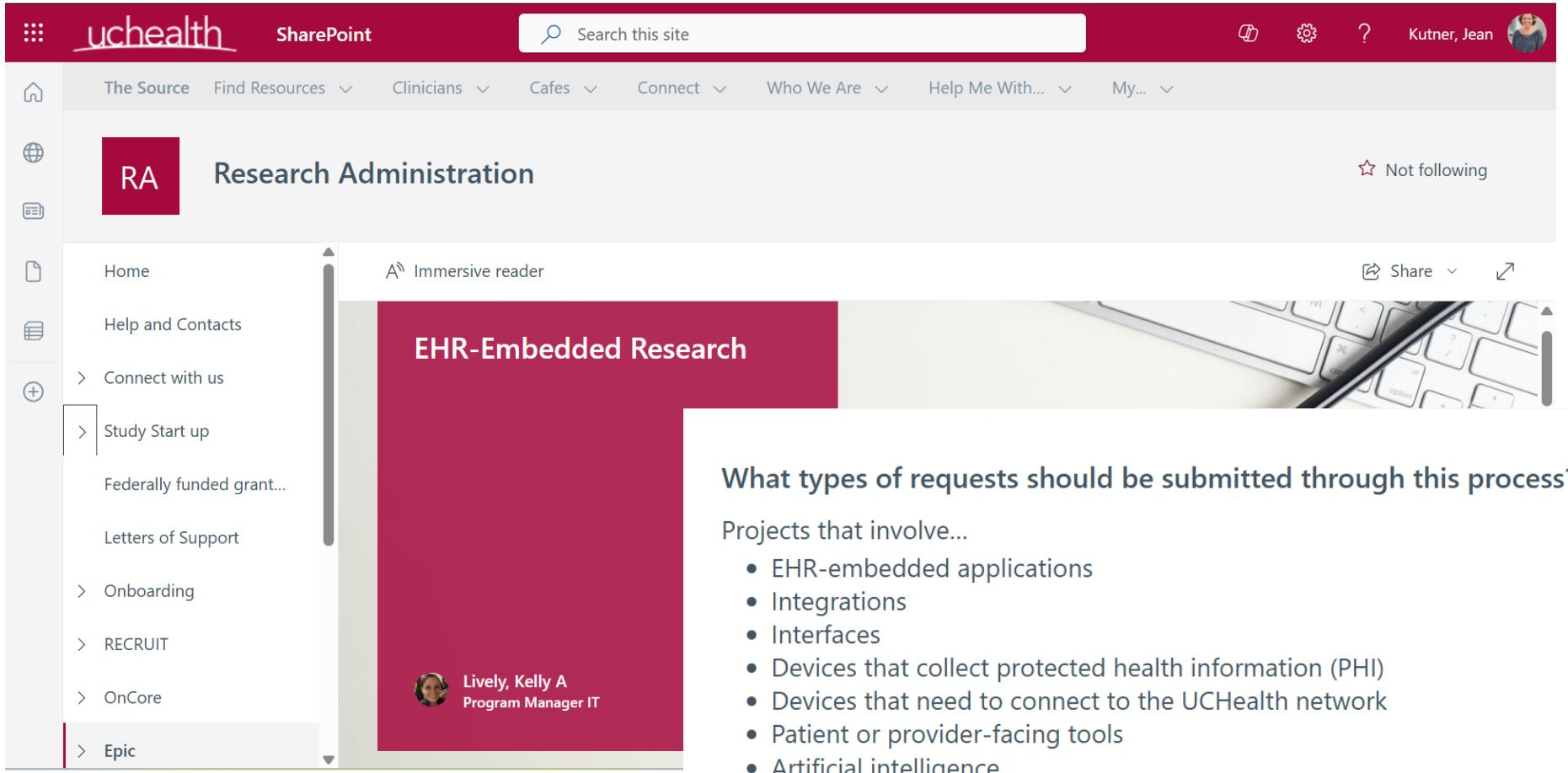


What types of requests should be submitted through this process?

Projects that involve...

- EHR-embedded applications
- Integrations
- Interfaces
- Devices that collect protected health information (PHI)
- Devices that need to connect to the UCHealth network
- Patient or provider-facing tools
- Artificial intelligence
- Customizing native Epic functionality for research use unless excluded below

Whether you're seeking an LOS for a grant, or you're ready to get started on your project, kick off the process by submitting a request!

Submit a Request

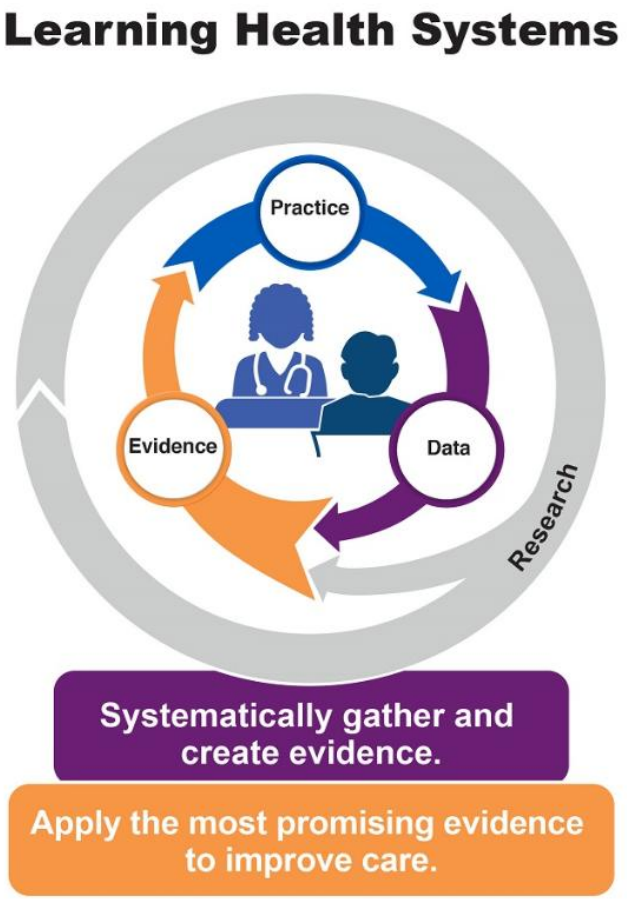
Resources

Process Diagram (Visio)

Summary – where is UCHealth on the learning health system journey?

Using the AHRQ definition…

- ✓ Have leaders who are committed to a culture of continuous learning and improvement.
- ✓ Systematically gather and apply evidence in real-time to guide care.
- ✓ Employ IT methods to share new evidence with clinicians to improve decision-making.
- ✓ Promote the inclusion of patients as vital members of the learning team.
- ✓ Capture and analyze data and care experiences to improve care.
- ✓ Continually assess outcomes refine processes and training to create a feedback cycle for learning and improvement.



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Envisioned Future

Enhanced alignment and collaboration between clinical and research missions with clinical care informing research and research informing clinical care

Integrated feedback cycles to continually assess outcomes and inform learning and improvement

Aligned structures, governance and resources to prioritize and facilitate projects across the quality improvement – research continuum

Discussion

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