CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

1570 Grant Street
Denver, CO 80203

DRAFT

Hospital Transformation Program

Intervention Proposal

I. Background Information

This Intervention Proposal is designed to clearly articulate the scope and goals of proposed transformation interventions aimed at impacting the hospital's selected local quality measures under the HTP. The following questions are meant to assist the state in identifying: the evidence base for each intervention; the need within targeted communities for the implementation of the interventions; and how the interventions will advance the goals of the HTP.

Hospitals will not be required to implement a specified number of interventions. Instead, participation requirements are based on the selection of local quality measures to impact within the five HTP Focus Areas:

- Reducing Avoidable Hospital Utilization
- Core Populations
- Behavioral Health and Substance Use Disorders
- Clinical and Operational Efficiencies
- Community Development Efforts to Address Population Health and Total Cost of Care

Hospitals will be required to address statewide measures for each Focus Area. Hospitals will also be required to select from the HTP list of local measures across the five Focus Areas based on community needs and the goals of the HTP. Each hospital will be required to work on a set of measures equal to 100 points. The number, mix and points per measure will vary according to hospital size, defined by bed count or specialty type:

- Large hospitals (91+ beds) will be accountable for six statewide measures, totaling 60 points and a minimum of four local measures, which will account for 40 points. Points per local measure will equal 40 divided by the number of local measures selected.
- Medium hospitals (26-90 beds) will be accountable for six statewide measures and a minimum of two local measures. If two local measures are selected, statewide measures will total 75 points, and local measures will account for 25 points. Points per local measure will equal 25 divided by the number of local measures selected. If three local measures are selected, then statewide measures will total 67 points and local measures will account for 33 points. Points per local measure will equal 33 divided by the number of local measures selected. If four or more local measures are selected, then statewide measures will then total 60 points and local measures will account for 40 points. Points per local measure will equal 40 divided by the number of local measures selected for four or more local measures.
- Small hospitals (<26 beds) excluding critical access hospitals will be accountable for six measures (statewide or local) to account for 100 points. Points per each measure will equal 100 divided by the number of measures selected.
- Critical access hospitals will be accountable for six measures (statewide or local) and will have their risk for measures reduced by 40%.
- Pediatric hospitals will be accountable for five statewide measures, totaling 50 points and a minimum of five local measures, which will account for 50 points. Points per local measure will equal 50 divided by the number of local measures selected.

- Respiratory specialty hospital(s) will be accountable for four statewide measures and a minimum of four local measures. If four measures are selected then statewide measures will total 56 points and local measures will account for 44 points. Points per local measure will equal 44 divided by the number of local measures selected. If five or more measures are selected, then statewide measures will total 50 points and local measures will total 50 points. Points per local measure will equal 50 divided by the number of local measures selected.

Hospitals have the option to work on local measures beyond the required minimum. This would spread the local measure risk by reducing the points per local measure.

In addition, hospitals have the option to replace a local measure with a statewide priority. Each statewide priority will be worth 20 points and if selected the points for each remaining local measure will be equal to the remaining total required local measure points divided by the number of local measures, greatly reducing the risk associated with those measures.

Hospitals should consult the Measure Scoring Summary, which can be found on the HTP webpage, for more information about measure selection, requirements and scoring.

Hospitals must then design five-year interventions that will impact their selected quality measures.

Hospitals must demonstrate that their proposed interventions will fulfill the goals of the HTP and are evidence-based. They must also justify the selection of each intervention based on the findings of the Community and Health Neighborhood Engagement process, including the environmental scan and feedback.

Each hospital will need to report its own data and submit its own application, but partnerships between hospitals may occur in some instances.

Hospitals may leverage existing resources for interventions, and existing interventions may be considered insofar as they expand or enhance the Department's noted goals and meet the following criteria:

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

In addition to meeting the above criteria, any hospital proposing existing interventions for participation in the HTP will be expected to propose and implement accelerated milestones in the Implementation Plan for such interventions.

This Intervention Proposal must be completed separately for each of the interventions being proposed for inclusion in the HTP. Hospitals must submit interventions that, together, address all of the statewide quality measures and the local quality measures listed in the hospital's response to Question 6 in the Hospital Application.

II. Overview of Intervention

1. Name of Intervention: SW-CP1 - Social Needs Screening and Notification

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

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

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

Response (Please format the response as a numbered list)
1.

3. Please use the space below to describe the intervention and the rationale for its selection. Responses should include:

- A description of the intervention;
- Who will be the target population for the intervention; and
- How the intervention advances the goals of the HTP:
  - ✓ Improve patient outcomes through care redesign and integration of care across settings;
  - ✓ Improve the patient experience in the delivery system by ensuring appropriate care in appropriate settings;
  - ✓ Lower Health First Colorado (Colorado's Medicaid Program) costs through reductions in avoidable hospital utilization and increased effectiveness and efficiency in care delivery;
  - ✓ Accelerate hospitals' organizational, operational, and systems readiness for value-based payment; and
  - ✓ Increase collaboration between hospitals and other providers, particularly Accountable Care Collaborative (ACC) participants, in data sharing and analytics, evidence-based care coordination and care transitions, integrated physical and behavioral care delivery, chronic care management, and community-based population health and disparities reduction efforts.

Response (Please seek to limit the response to 1,000 words or less)
This measure ensures that all Medicaid patients discharged home from an inpatient setting have a documented formal social needs screening completed during or within 12 months of admission, and that a positive screen result in appropriate referrals for services and notification to the RAE.

By formally assessing needs, making referrals for services where appropriate, and by communicating such referrals back to the RAE, continuity of care will be increased. This intervention will increase health outcomes and reduce healthcare costs.

Successful implementation of this intervention will require development of a standardized tool for the assessment of needs, identification of and referral to relevant services, documentation of assessment and referral, and the ability to consistently refer this information back to the correctly assigned RAE for each patient. We will work with the RAE to identify community resources and will utilize our health information exchange partner, CORHIO, to send the screening and referral information back to the RAE for outpatient follow up.

4. Please use the space below to describe how the intervention and any selected local quality measures to be addressed by the intervention align with community needs identified throughout the Community and Health Neighborhood Engagement process (including data identified in the hospital's CHNE midpoint and final reports), including but not limited to:
    - How the intervention and any selected local quality measures to be addressed by the intervention were selected based on identified community needs, including how they align with identified significant behavioral and physical health needs and / or service capacity resources and gaps, including related to care transitions and social determinants of health;
    - How the population of focus aligns with identified community needs; and
    - How the proposed intervention will leverage available medical and / or social resources and partners.

Response (Please seek to limit the response to 1,500 words or less)
The CHNE indicated that Presbyterian St. Luke's Medical Center's Medicaid patient population is impacted by social barriers that lead to a lack of follow up care. Barriers include inadequate food and housing, which inevitably impact the health of those affected.

Transportation to follow up care was also identified as a need among patients in the CHNE due to a lack of a robust public transportation system, and the challenges of medically impacted people to make use of public transport safely and effectively.

CHNE revealed that Presbyterian/St. Luke's (P/SL) has a population of patients without access to primary care and specialty services due to few providers accepting Medicaid and lack of afterhours or weekend services. A lack of timely follow-up with primary care services has been identified as a risk factor for this population as well.

The senior population in Denver lacks resources and tools to manage a complex healthcare system, which can contribute to need for hospitalization, readmission, as well as higher costs of care.

Furthermore, the current economic climate related to the COVID 19 pandemic has introduced job loss and subsequent loss of health insurance, as well as an increase in financial hardship. Both a lack of insurance and an increase in financial instability contribute to an increase in the Medicaid population within Denver and surrounding counties and the Presbyterian St. Luke's catchment area.

5. Please identify the evidence base (academic, professional or otherwise) related to this intervention's use among the target population by selecting one of the following options:

   (1) Randomized Control Trial (RCT) level evidence
   (2) Best practice supported by less than RCT evidence
   (3) Emerging practice
   (4) No evidence

If you selected option 1, 2 or 3 above, please use the space below to summarize the evidence base (academic, professional or otherwise) related to this intervention's use among the target population. The response should address the intervention's ability to impact the selected local and statewide quality measures identified in Question 6 in the Hospital Application. Please submit the response in narrative form and provide links to any reference documentation (data, citations, etc.).

If you selected option 4 indicating that there is no known evidence base, please explain why this intervention is being proposed regardless.

Response (Please seek to limit the response to 1,500 words or less)
This measure attempts to address what are commonly known as Social Determinants of Health (SDoH) defined by the World Health Organization (WHO) (2021) as "the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life." The United States Office of Disease Prevention and Health Promotion (2021) through the Healthy People 2020 program, further reaffirms that these conditions impact health, well-being, life-expectancy, as well as health care costs and utilization.

Evidence exists to show how housing insecurity, food insecurity, and violence negatively impacts health care utilization and outcomes. Kushel, Vittinghoff, & Haas, (2001) discussed homeless as a SDOH. Ma, Gee, & Kushel,(2001) focused on the outcomes related to care provided to low income children. Lastly, the work of Bonomi, Anderson, Rivara, & Thompson (2009) correlated how violence affects healthcare utilization.

Our focus in this intervention is to evaluate the five core domains that include: housing insecurity, food insecurity, transportation problems, utility help needs, and interpersonal safety. These domains align with the tool developed by the Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities (AHC) Health-Related Social Needs Tool (2007). It is our intention to evaluate the tools identified by CMS for adoption to our patient population and this intervention.

References:

Bonomi, A.E., Anderson, M.L., Rivara, F.P., & Thompson, R.S. (2009). Health care utilization and costs associated with physical and nonphysical-only intimate partner violence. Health Serv Res. Jun;44(3):1052-67. doi: 10.1111/j.1475-6773.2009.00955.x. Mar 17. PMID: 19674432; PMCID: PMC2699921.

Cutts, D. B., Meyers, A. F., Black, M. M., Casey, P. H., Chilton, M., Cook, J. T., Geppert, J., Ettinger de Cuba, S., Heeren, T., Coleman, S., Rose-Jacobs, R., & Frank, D. A. (2011). US Housing insecurity and the health of very young children. American journal of public health, 101(8), 1508–1514. https://doi.org/10.2105/AJPH.2011.300139

Kushel, M.B., Vittinghoff, E., & Haas, J.S. (2001). Factors associated with the health care utilization of homeless persons. JAMA.Jan 10;285(2):200-6. doi: 10.1001/jama.285.2.200. PMID: 11176814.

Ma, C.T., Gee, L., & Kushel, M.B. (2008).Associations between housing instability and food insecurity with health care access in low-income children. Ambulatory Pediatrics,Volume 8, Issue 1,Pages 50-57,ISSN 1530-1567,https://doi.org/10.1016/j.ambp.2007.08.004.

Office of Disease Prevention and Health Promotion. (2020, December 8). Healthy people 2020.

World Health Organization (WHO).(2021). Social determinants of health. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

6. a. Does the focus of the proposed intervention intersect with ongoing initiatives statewide (including, but not limited to those included in the ACC, State Innovation Model and Comprehensive Primary Care Plus)?

☒ Yes

☐ No

b. If yes, please identity the applicable statewide initiative(s): (you may select more than one response from the list below)

☐ Behavioral Health Task Force

☐ Affordability Road Map

☒ IT Road Map

☐ HQIP

☐ ACC

☐ SIM Continuation

☐ Rx Tool

☐ Rural Support Fund

☐ SUD Waiver

☐ Health Care Workforce

☐ Jail Diversion

☐ Crisis Intervention

☐ Primary Care Payment Reform

☒ Other: Polis-Primavera Roadmap, SNAP, TANF, food stamps program, FINI, LIEAP. (please identify)

Please also use the space below to briefly explain how the hospital will ensure the intervention aligns with the applicable ongoing initiative(s).

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

This intervention intersects with several statewide initiatives and pre-existing programs. One of the goals of the Polis-Primavera Affordability Roadmap is to increase access to healthy food, housing, and other social services as they fully impact the wellbeing of individuals and families. Pre-existing state programs include section 8 housing, various homeless shelters and day programs, Denver's Road Home, the Colorado Coalition for the Homeless, the Supplemental Nutrition to Assistance Program (SNAP), Temporary Aid to Needy Families (TANF) and food stamp programs, the USDA Food Insecurity Nutrition Incentive Grant (FINI) to incentivize the purchase of fruits and vegetables, the Medicaid medical transportation program and Access-A-Ride, the Low-Income Energy Assistance Program (LIEAP) for help with utilities and the United Way 211-referral line. Addressing domestic violence, there is interface with law enforcement, Child and Adult Protective Services, Safehouse Denver, Gateway Domestic Violence Services and the Colorado Coalition against Domestic Violence.

This intervention intersects with the following statewide interventions:

SW-BH1:Collaboratively develop and implement a mutually agreed upon discharge planning and notification process with the appropriate RAEs for eligible patients with a diagnosis of mental illness or substance use disorder (SUD) discharged from the hospital or ED.

SW-RAH1: Adult 30-day all-cause risk adjusted readmission rate

By identifying social needs early, patients care receive resources, education, and support related to their health, which will decrease readmission. Screening for social needs and evaluating needs in patients with a diagnosis of mental health illness or substance use disorder (SUD) will guide what referrals are made for these patients after discharge. Notifications will be sent to the RAEs who can help with patient follow up, compliance, and obtaining further resources to improve patient care and decrease hospital readmission.

7. Please use the space below to explain any experience the hospital or any affiliated community partners have had with this type of intervention or target population and how that experience will support the success of the intervention.

Response (Please seek to limit the response to 500 words or less)
This would be an entirely new interaction between the hospital and the RAE. We have worked together in the past to coordinate follow up primary care visits for patients discharging from the hospital but there is no precedent for specifically evaluating the social needs of patients and communicating the information back to the RAE.

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

☒ Yes

☐ No

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

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

Response (Please respond as applicable; Please seek to limit the response to 1,000 words or less)
The current process for evaluating the social needs of hospitalized patients relies primarily on referral to case management from physicians, nursing, other staff, or by patients and families themselves. Historically, the focus of case management at Presbyterian St. Luke's Medical Center has been discharge planning and utilization review, and there is no process specifically for the evaluation of social needs unless it impedes hospital discharge. Our evaluation process consists of a Discharge Planning Entry within 24 hours of admission to assess basic patient needs and establish baseline understanding of what a particular patient may need upon discharge. If high-risk factors are identified through that evaluation, a 'High Risk Visit' is performed by the social worker to address those additional needs. The Discharge Planning Entry is conducted within 24 hours of admission. When made aware of needs, social work at P/SL assists in locating appropriate resources for patients, but there has been little to no communication back to the RAE about these efforts unless a patient already has an established Medicaid case worker. We believe that by participating in this intervention, we can enhance the pre-existing relationship with the RAEs, creating a standardized structure for assessing risk of SDOHs, and connecting our patients with important community resources to improve their health outcomes.

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

☒ Yes

☐ No

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

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

Partner Organization Name	Type of Organization	Does the hospital have any previous experience partnering with this organization? (Yes or No)	Organization's Role in Intervention Leadership and Implementation (high-level summary)
Colorado Access	Regional Accountability Entity	Yes	Signing off on template for assessment of SDoH and providing coordination to referral sources as needed

c. Please also submit documentation of the partnership with each listed organization. Documentation may be provided separately for each organization listed above and could include: a contract; a memorandum of understanding; a business association agreement; a Letter of Partnership from the listed organization(s); or similar documentation. If a Letter of Partnership is provided, in it the organization should: (1) acknowledge that it intends to partner; (2) provide a brief description of the organization; (3) express agreement with the planned intervention; and (4) express agreement with the planned role it will have in leadership and implementation of the intervention as expressed above. The letter should be signed by a member of the organization's management and submitted with this application in the same .pdf document. The Letter of Partnership Template can be found on the HTP webpage.