CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

1570 Grant Street
Denver, CO 80203

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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.

DRAFT

- 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.

DRAFT

II. Overview of Intervention

1. Name of Intervention: Behavioral Health Care Coordination

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. SW-BH1: Behavioral Health Collaborative Discharge Planning Process & Notification to the RAE

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)

Studies consistently show a direct correlation between ED utilization patterns, substance abuse disorders, and mental illness. Over 50% of emergency room patients have a mental illness diagnosis. This same group has higher rates of mortality and morbidity, sustain higher medical

DRAFT

costs over time and have higher social and community needs like homelessness, food instability, and addiction disorders (Niedzwiecki et al. 2018).

To address this measure, Rose Medical Center's intervention will include:

1. Engaging our RAE (regional accountable entity) and relevant community partners to create a collaborative discharge planning process that selectively matches available resources to this at-risk population.

2. Developing and using an evidence-based or best practice data sharing platform to transmit discharge planning information, pertinent medical records, and referrals for patients with a primary or secondary diagnosis of mental illness or substance use disorder (with the patient's consent).

It is imperative we collaborate with our RAE's and connect them to our patients with behavioral health and substance use disorders as the primary goal of the RAE is to coordinate members' care and ensure they are connecting with primary and behavioral health care post hospitalization.

Target Population:

Adult patients (18+) with a primary or secondary diagnosis of mental illness or substance use disorder (SUD) admitted in the ED or inpatient at Rose Medical Center. Patient's must give consent to allow this referral to our community partners and must have Medicaid as their primary payor source.

How the intervention will advance the goals of HTP:

The proposed intervention aligns with several HTP objectives. One, it can significantly impact and improve patient outcomes by ensuring integration of care is occurring among diverse agencies/providers across various settings in the community.

Second, the proposed intervention can improve patient experience through proactive discharge planning and seamless progression through the continuum of care.

Third, our proposed intervention may lead to lower costs related to avoidable readmissions, length of stay, and overutilization of the emergency department through effective care coordination and care transitions modeling.

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

DRAFT

- 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)
Rose Medical Center's CHNE (Community and Health Neighborhood Engagement) revealed:

Individuals with behavioral health and substance use disorders experience difficulties with getting and keeping jobs.

Similar to individuals with multiple co-occurring conditions, individuals with behavioral health and substance use disorders are often survivors of trauma.

70.0 percent of women in the service area experienced one or more major life stress events 12 months before delivery .

Admission rates may reflect the underlying behavioral health and access to care issues in the community. For example, in the Rose service area, more than one in ten (10.4 percent) adults experience depression. Yet 8.1 percent of the population reported needing mental health care in the past 12 months but not being able to receive it.

Smoking, unhealthy weight, and poor nutrition were flagged as especially problematic for individuals with behavioral health (including substance use) concerns, as well as poor oral health. This may be a result of their behavioral health conditions but also due to medications they may be taking to treat their conditions.

About one in five (20.6 percent) adults in Rose's service area binge drink and 15.3 percent of high school age adolescents reported having five or more drinks within a few hours.

Alcohol abuse is the most common APR DRG diagnosis for Medicaid hospital admissions among enrollees living in RAE 5 and RAE 6 who used hospital services. It is the sixth highest in RAE 3.

Alcohol abuse ranks in the top five reasons for an Emergency Department admission among all three RAEs.

Residential and outpatient substance use treatment services were identified as especially limited, even more so for individuals with both behavioral health (mental health and substance use) and physical health concerns.

Based on the CHNE findings, it's critical to connect patients with SUD's and/or mental health diagnosis with primary care physicians and outpatient treatment resources. It is anticipated the establishment of apropriate outpatient care will decrease inappropriate utilization of emergency department services and increase compliance with appropriate follow up care.

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

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

DRAFT

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

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

Response (Please seek to limit the response to 1,500 words or less)
Best practice supported by less than RCT evidence.

Numerious studies indicate patients with behavioral illness and substance use disorders (SUD) have unnecessary ED visits, longer lengths of stay, and are more likely to be noncompliant with treatment recommendations. The call to action for all clinicians is that it's no longer enough to just identify and diagnose these disorders, but we must treat these illnesses and provide long term support services to sustain our patient's well-being and overall care.

According to the literature, approximately 50% of frequent ED users have a mental health diagnosis and often have many issues that historically have been considered nonmedical, including homelessness and food insecurity. Up to 80% of patients with mental illness seek care in medical—instead of behavioral care—settings, where they often leave without treatment for mental illness (Niedzwiecki et al. 2018).

Fitch, Iwasaki, and Villa (2014) completed a study on resource utilization and cost for patients with schizophrenia. They found improved medication compliance among Medicaid recipients who had schizophrenia showed savings over $106 million in inpatient acute care costs. Health Care Policy and Financing in Colorado estimates potentially avoidable costs of SUD (substance use disorder) at $63,000,000. For every $1 invested into SUD treatment there is a $4 savings in healthcare costs (Estee et al., 2006).

Research suggests that clinicians should improve access to outpatient services to decrease unnecessary utilization of emergency departments for mental health and substance use issues (Lee et al., 2017). The American College of Emergency Physicians (2017) believes emergency medical professionals are positioned and qualified to mitigate the consequences of alcohol abuse through screening programs, brief intervention, and referral to treatment. Research also indicates that $3.81 is saved for every $1 spent on screening and intervention (Gentilello et al., 2005).

In a literature review of care transition interventions in mental health, nine elements of care were proposed to ensure successful transitions of care for patients discharging from inpatient settings. This guidline includes: identifying high risk patients, patient/family engagement, client centered transition planning, identifying care pathways (procedural guidelines), ease of information transfer for all care providers, use of transition coaches, ensuring provider engagement, utilizing quality metrics and feedback, and shared accountability and expectations for all providers (Viggiano et al 2012).

DRAFT

Rose Medical Center plans to follow the successes outlined in the literature described above by incorporating elements of the effective programs in our collaborative practice guidelines.

CITATIONS:

Estee, S., He, L., Mancuso, D., Felver, B. (2006). Medicaid cost outcomes. Department of Social and Health Services, Research and Data Analysis Division: Olympia, Washington. Retrieved from https://www.dshs.wa.gov/sites/default/files/rda/reports/research-4-61.1.2007.2.pdf

Fitch, Iwasaki, and Villa. Resource Utilization and Cost in a Commercially Insured Population with Schizophrenia. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4031739/

Gentilello LM, Ebel BE, Wickizer TM, Salkever DS, Rivara FP. Alcohol interventions for trauma patients treated in emergency departments and hospitals: a cost benefit analysis. Ann Surg. 2005;241(4):541–50. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1357055/

Lee, S., Herrin, J., Campbell, R. (2017). Predictors of return visits among insured emergency department mental health and substance abuse patients. Western Journal of Emergency Medicine: 18 (5).Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5576625/

Niedzwiecki, Sharmka, Kanzaria 2018. NJAMA Network. Factors Associated With Emergency Department Use by Patients With and Without Mental Health Diagnoses 2018. Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2707424

Viggiano, T., Pincus, H., Crystal, S. Current Opinion. Care transition interventions in mental health. November 2012. Retrieved from https://static1.squarespace.com/static/55ba9fe5e4b09e80d21790f7/t/5db07eeb4769ff43a06a832d/1571847916349/Care_transition_interventions_in_mental_health.pdf

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

DRAFT

- ☐ Rx Tool
- ☐ Rural Support Fund
- ☐ SUD Waiver
- ☐ Health Care Workforce
- ☐ Jail Diversion
- ☐ Crisis Intervention
- ☐ Primary Care Payment Reform
- ☐ Other: ____ (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)
Two goals for the accountable care collaborative is to combine the management of physical and behavioral health under one accountable entity and to strenghten the coordination of services among service providers for Medicaid recipients. Under the ACC, RAE's (regional accountable entities) were contracted out, which Rose Medical Center currently works alongside, and will continue to work alongside, for the HTP interventions described above. Strenghtening our coordination of services together will assist in the efforts of reducing avoidable hospitalizations, reducing length of stay and improving overall patient outcomes. The collaboration with our RAE's will also ensure a safe discharge handoff and continuation of much needed services for underserved members of our community.

This intervention also intersects with the Behavioral Health Task Force who's goal is to identify systemic gaps and enhancements in access to behavioral health services, especially for vulnerable or underserved populations. Participating in this intervention directly addresses closing the gap in services for our at-risk patients.

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)
Rose Medical Center and our RAE partners currently have processes in place to identify at-risk patients admitted to the emergency department and the medical floors. The RMC case management team makes referrals to COA (Colorado Access) for any medicaid recipient that is in need of community resources upon discharge.

COA (the RAE provider) also utilizes CORHIO to identify patients that may be at-risk for readmission or in need of post hospitalization follow up care, support and resources.

The COA care management team provides members transitioning from hospital settings to lower levels of care with appropriate transitions of care intervention, including, but not limited to:

a. Collaboration with hospital staff to uphold timely and member-focused discharge planning;

DRAFT

b. Development of member-driven care plans that incorporate current member status and needs, interdisciplinary team input, and historical clinical information;

c. Submission of member referrals that support ease of access to services and remain consistent with identified member needs;

d. Care coordination activities designed to ensure sustained member access to care and reduce risk for future hospitalization;

e. Exchange of member information, clinical records, care plan goals, and care coordination activities to promote interdisciplinary service delivery;

f. Follow up with member, provider, and hospital team members to ensure follow through with treatment activities and member success

Prior to COVID-19, liaisons from Colorado Access were allowed entry into hospitals for ongoing trainings and collaboration-building events with the case management team. We hope to return to the robust partnership when it is safe to do so.

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)
Rose Medical Center actively screens patients for suicidality, behavioral health disorders, and substance use needs. Patients who screen positive for acute mental health issues are evaluated for level of care/placement by the HealthOne Crisis Assessment Team. Individuals who screen positive for substance use issues and consent to aftercare resources are provided community resources as applicable to their needs. There is no current standardized process in collaborating with our COA RAE partners for these at-risk patients.

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

DRAFT

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

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

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

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