CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

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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: 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

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)

The intervention selected to address the behavioral health collaborative discharge planning process and notification to the Regional Accountable Entity (RAE) quality measure entails identifying eligible[1] patients 18 years or older who are discharged from the hospital or emergency department with a principal or secondary diagnosis of mental illness or substance use

disorder. Our implementation plan will include engaging the RAE and relevant community partners to create collaborative discharge planning processes that intentionally matches available resources to appropriate segments and/or risk profiles of the eligible population. We intend on leveraging our health information exchange partner, CORHIO, to send the hospitals admit, discharge, and transfer information to the RAEs. Consistent with continuous quality improvement principles, ongoing intervention modifications may need to occur to impact other HTP outcomes such as readmission rates, or to accommodate evolving needs of our staff, community and patients alike.

We believe this intervention will advance the goals of the Hospital Transformation Program by improving both patient outcomes and experience by ensuring integration of care is occurring across the appropriate settings. By indulging in the HTP framework, we are organically accelerating the hospital's readiness for value-based payments with the intention to reduce costs. Furthermore, we are highlighting the collaboration among our community partners via data sharing and analytics, evidence-based care coordination and care transitions, integrated physical and behavioral health care delivery, and chronic care management.

[1] Eligible patients are those who give consent or for whom state and federal statutes allow notification without consent. Implementation plans for this measure must include a robust process for seeking patient consent.

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)

Connecting patients with substance abuse disorders or mental health diagnosis with primary care physicians will decrease inappropriate utilization of emergency department services and increase compliance with appropriate follow up care. During the CHNE process, stakeholders identified patients with mental health illness and substance abuse as a population underserved. This feedback was a common theme and repeatedly heard from stakeholders. Therefore, the proposed intervention demonstrates that the population of focus, aligns with the community needs as identified above. The exercise of the CHNE process allowed us to gather resources available to the community for the specific needs identified. We will leverage this knowledge of resources available to the needs of our community.

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

   (1) Randomized Control Trial (RCT) level evidence

(2) Best practice supported by less than RCT evidence
(3) Emerging practice
(4) No evidence

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

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

Response (Please seek to limit the response to 1,500 words or less)

Best Practice: In their guide on behavioral health care approaches, the Advisory Board (2011a) outlines the concerns with unmet behavioral health needs: people with behavioral illness have unnecessary ED visits, longer lengths of stay, and are more likely to be noncompliant with treatment recommendations. Advisory Board concludes that it is not enough to identify behavioral health concerns, but they must be treated as well. They reference their findings that one study found improved medication compliance among patients who had schizophrenia and were Medicaid beneficiaries could save $106 million in inpatient acute care costs. A recent study estimates that the cost of care for people with behavioral illness can be 60-75% greater than the population at large (Advisory Board, 2013). For patients who do find themselves in the ED, Advisory Board recommends taking a proactive approach that takes advantage of the opportunities presented to provide high-quality transitions of care by fostering strong partnerships with community providers to offer a continuum of community care when the patient is discharged.

In order to transition patients to community-based services, it is essential to understand why they are utilizing the ED in the first place (Advisory Board, 2019b). For many, a shortage of behavioral health professionals leaves them without any options for treatment outside of acute care. Some patients are reticent to seek help because of lingering stigma or uncertainty of costs. Still, others are unsure of their insurance coverage for such services. However, increasing access to appropriate, timely outpatient behavioral health treatment options is critical in cutting back on unnecessary behavioral health-related acute care visits.

Advisory Board (2015) has noted that more and more patients are beginning to access behavioral health treatment in the outpatient setting and has identified three trends contributing to this pattern. First, demographics are changing. The age group most likely to use behavioral services, those ages 25-44 years, is growing. Second, reimbursement for outpatient treatment has been more available due to increased coverage of behavioral health services through legislative mandates. Lastly, creative practices such as early screening and detection in primary care offices mean people can appropriately and effectively be treated in the outpatient setting, which is becoming the preferred treatment modality supported by reimbursement models.

For patients who do find themselves in the ED, there are several strategies one can use to decrease length of stay including ED-based telehealth for psychiatric patients, making use of crisis stabilization units to divert patients from the ED, and accessing a behavioral health

discharge clinic to transition to a more appropriate setting which lowers the risk of ED visits (Advisory Board, 2019a). For example, Atrium Health used telehealth and decreased the length of stay for their behavioral health population by 2.5 hours during a time when ED volume increased by 37%. Intermountain diverted patients to a crisis stabilization unit, which costs about one-third of what an ED visit would cost and decreased behavioral health ED visits by 50% in one year. Finally, Massachusetts General started a Bridge Clinic for patients leaving the ED to offer same day Medication Assisted Treatment (MAT), and only about 10% were readmitted within 30 days.

Several programs for reducing behavioral health readmissions and hospital stays have been identified in the literature. The Program of Assertive Community Treatment (PACT) was developed in Wisconsin in the 1960s and 1970s (Advisory Board, 2011b). This program employed a team of psychiatrists, nurses, pharmacists, social workers, and occupational therapists to provide community-based treatment for those with severe mental illness. They found that patients in the program saw improvement in health and health spending, personal relationships, legal trouble, and substance abuse. They also saw a decrease in the average number of hospital days per year for the participants. This program can be adjusted to meet modern concerns; for example, in Oklahoma, the PACT team members for a participant are immediately notified when the participant is admitted to the ED or has law enforcement contact.

Massachusetts General developed a three-step approach to reducing readmissions among people with substance use disorders (Wirth and Ogundimu, 2019). They first utilized a multi-disciplinary addiction consult team to address substance use during inpatient admissions, which they estimate cut odds of readmission by 25%. Next, they opened an ED-based walk-in center for substance use disorder care, where only 10% of those patients are readmitted within 30 days. Finally, they developed strong relationships with their community mental health centers and the peer recovery coaches specifically, and incorporated care into primary care clinics, which reduced inpatient days by 9% and ED visits by 15%. Wirth and Ogundimu report that Massachusetts General had three pillars to their approach: engaged leaders who educated other staff on substance use disorders and evidence-based treatment, same-day access to MAT, and education for all staff to reduce bias.

Another study of San Francisco General Hospital implemented a discharge protocol for patients with dependence on alcohol, which included assessment and medication assisted treatment (MAT) when appropriate (Wei, Defries, and Lozada et al., 2015). They discovered that the use of such protocol increased MAT from 0% to 64% and reduced readmissions from 23.4% to 8.2%. Additionally, all-cause visits to the ED within 30 days of discharge decreased from 18.8% to 6.1%.

Viggiano, Pincus, and Crystal (2012) conducted a literature review of care transitions interventions for patients discharging from psychiatric inpatient stays and proposed nine critical components of care transition programs. They include prospective modeling or identifying those at greatest risk, authentically engaging the patient and family in the treatment plan, quality transition planning for the next level of care, identifying care pathways, ensuring information is accessible to all team members including those who will be treating the patient after discharge, utilization of transition coaches or agents, engaging providers with clear responsibilities and formal communication procedures, utilizing quality metrics and feedback on post-discharge outcomes to drive improvement, and shared accountability in both benefits and risks.

Standardized practice guidelines were studied by Medves et al. (2010), who conducted a literature review of the distribution and implementation of such practice guidelines in team-

based healthcare settings. Of the 88 studies included in their review, 72.7% showed that the dissemination and adaptation of such standardized guidelines had statistically significant improvements in provider knowledge, practice outcomes, and cost savings. One such well-known example of standardized practice guidelines influencing behavioral health outcomes is the Zero Suicide protocol originally adopted by the Henry Ford Health System in Michigan (Coffey and Coffey, 2016). Zero Suicide is a program meant to change the culture of health care systems as well as adopt standardized practices to prevent suicide among the patients treated. The Henry Ford Health System saw suicides among their population drop by 80% and sustained this success for a decade, even though suicides increased during that time period in the general population of Michigan.

Sky Ridge Medical Center plans to mimic the successes outlined in the literature by incorporating elements of the effective programs in our collaborative practice guidelines. For instance, while Viggiano, Pincus, and Crystal (2012) discuss elements of successful discharges from psychiatric inpatient hospitals, many of the components that they found could be applicable to acute care hospitals treating patients with behavioral health needs. Additionally, the success of San Francisco General Hospital's standardized discharge protocol encourages the use of standardized guidelines in the approach to patients with behavioral health needs. The work of Medves et al. (2010) and Coffey and Coffey (2016) prove that standardized practice guidelines are an effective way to impact the care of patients with behavioral health needs.

CITATIONS:

1. Advisory Board. Guaranteeing Timely Access to Urgent Psychiatric Care: The Behavioral Health Access Playbook Part 2 of 5. Research Report. Population Health Advisor. 2019.

https://www.advisory.com/-/media/Advisory-com/Research/PHA/Resources/2019/ED-Strategies-for-Behavioral-Health_PHA_2019.pdf

2. Advisory Board(b). PACT Program for Severe Mental Health Conditions: Reduces Costs, Improves Patients' Quality of Life, and Provides an Alternative to Inpatient Psychiatric Units. Executive Research Briefing. November 18, 2011.

https://www.advisory.com/research/health-care-advisory-board/white-papers/2011/pact-program

3. Advisory Board. Proactive Behavioral Health Management. Research Briefing. Health Care Advisory Board Care Transformation Center. 2013.

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4. Advisory Board (a). Revamp Your Approach to Behavioral Health Care: Three Imperatives to Sustainably Advance Care Quality. Executive Research Briefing. November 21, 2011.

https://www.advisory.com/research/health-care-advisory-board/white-papers/2011/revamp-your-approach-to-behavioral-health-care

5. Advisory Board. Three Trends Increasing Outpatient Behavioral Health Utilization. Population Health Advisor. 2015.

https://www.advisory.com/-/media/Advisory-com/Research/PHA/White-Papers/2015/Three-Trends-Increasing-Outpatient-Behavioral-Health-Utilization/White-Paper.pdf

6. Advisory Board. Understanding the Behavioral Health Access Problem: The Behavioral Health Access Playbook Part 1 of 5: Executive summary. Population Health Advisor. 2019.

https://www.advisory.com/-/media/Advisory-com/Research/PHA/Resources/2019/Overcoming-the-Behavioral-Health-Access-Challenge_PHA_2019.pdf

7. Coffey, M. and Coffey, E. How We Dramatically Reduced Suicide: Case study. NEJM Catalyst. The Menninger Clinic, Houston, Texas. April 20, 2016.

https://catalyst.nejm.org/dramatically-reduced-suicide/.

8. Medves, J. et al. Systematic review of practice guideline dissemination and implementation strategies for healthcare teams and team-based practice. International Journal of Evidence-Based Healthcare. 2010. 8:79-89. DOI: 10.1111/j.1744-1609.2010.00166.x.

https://www.ncbi.nlm.nih.gov/pubmed/20923511

9. Viggiano, T., Pincus, H., Crystal, S. Care transition interventions in mental health. Current Opinion Psychiatry. Volume 25, Number 6: 551-558. November 2012. DOI: 10.1097/YCO.0b013e328358df75.

https://www.ncbi.nlm.nih.gov/pubmed/22992544

10. Wei, J., Defries, T., Lozada, M. et al. An Inpatient Treatment and Discharge Planning Protocol for Alcohol Dependence: Efficacy in Reducing 30-Day Readmissions and Emergency Department Visits. J GEN INTERN MED (2015) 30: 365.

https://doi.org/10.1007/s11606-014-2968-9.

11. Wirth, C. and Ogundimu, T. Massachusetts General's 3-step approach that cut readmission risk for substance use disorders by 25%. Advisory Board. March 14, 2019.

https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2019/03/substance-use-disorder

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: Douglas County Care Compact, Rocky Mountain Human Services (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)

Douglas County Care Compact is being piloted at Sky Ridge Medical Center.

Rocky Mountain Human Services has a behavioral health transition specialist program and the momentum program.

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)

The hospital or any affiliated community partner, such as the RAE, does not have any experience with the intervention as the collaborative discharge planning process does not currently exist. However, the RAE has provided the following prior experience with this target population, and based on this experience, it will support the success of our future initiative. Colorado Access (COA) receives CORHIO ADT feeds as well as periodic contacts from hospitals. This information allows COA to risk stratify to target interventions for those members who have complex medical issues. 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;

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

Colorado Access manages behavioral health utilization closely for ensuring that members with behavioral health needs are treated at the lowest level of care necessary for safety and efficacy. The behavioral health care management team also work with hospitals and outpatient providers to enable seamless care for the member.

Currently, Colorado Access efforts have been aimed at transition from inpatient care. Colorado Access does not receive timely notification of emergency department visits.

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

☐ Yes

☒ No

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

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

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

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

☒ Yes

☐ No

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

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

Partner Organization Name	Type of Organization	Does the hospital have any previous experience partnering with this organization? (Yes or No)	Organization's Role in Intervention Leadership and Implementation (high-level summary)
Colorado Access		Yes	Manages behavioral health utilization closely for ensuring that members with behavioral health needs are treated at the lowest level of care necessary for safety and efficacy.

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.