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: CP6 Screening and Referral for Post-Partum Depression and Anxiety to the RAE

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. CP6: Screening and Referral for Postpartum Depression and Anxiety 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)

Postpartum depression (PPD) and anxiety can be debilitating to a new mother and her family. When new mothers are routinely screened PPD and anxiety can be appropriately managed. Rose Medical Center routinely screens postpartum women with the Patient Health Questionnaire-9

(PHQ-9) before discharge. Designated scores trigger different interventions. If the patient has a higher score, a social worker will consult with the patient before discharge to determine if she requires extra resources.

This intervention selected addresses the screening and referral of a mother who screens high on the PHQ-9. For this intervention, Rose Medical Center will establish a process to refer Medicaid mother who screen at 15 or above on the PHQ-9 to a Regional Accountable Entity (RAE) for appropriate follow-up. The RAE referral will ensure optimal patient access and follow-up for this patient population. Our implementation plan will include engaging the RAE and relevant community partners to create a streamlined communication system to notify regional mental health providers of the depression and anxiety risk of their members of the eligible population. The interventions described will be implemented for all inpatients regardless of payer source admitted to Rose Medical Center. In order to improve patient outcomes for our most vulnerable and underrepresented groups, our target population will be on inpatient adults (over the age of 18) who have Medicaid as their primary insurance provider. We intend on leveraging our health information exchange partner, CORHIO, to send the hospital admit, discharge, and transfer information to the RAEs. The increased efficiency in communication and coordination with the RAEs will improve the patients experience. Consistent with continuous quality improvement principles, ongoing intervention modifications will occur to ensure we will best meet the needs of our patients, community and staff alike.

This intervention will advance the goals of the Hospital Transformation Program by improving the patient and their family's outcomes by ensuring timely integration of local mental health resources into the patient's plan of care. Our efforts with this measure in the HTP framework will help to prevent adverse outcomes for mother and families, and will proactively limit the burden on an already stressed mental health system. These steps will help decrease readmission rates by connecting high risk patients with community resources. Furthermore, we are highlighting the collaboration among our community partners via data sharing, evidence-based care coordination and care transitions, integrated physical and behavioral health care delivery, and chronic care management.

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)
CDPHE data from their Vision analytics program reports that in 2016-2018 10.3% of Denver county residents self-reported their mental health as "not good" in the previous 2 weeks and 11.1 reported the same over the last 30 days. More specifically, CDPHE reports that since 2012

maternal depression has been increasing in the State of Colorado and in 2017 was prevalent in 11.3% of recent mothers and 10.4% of recent Denver mothers. Additionally, CDPHE vision data reports that prenatal depression counseling was received by only 77.4% of Denver county recent mothers in 2015-2017. CDPHE further reports that since 2012 post-partum depression is highest in mothers 15-19 years old, at 20.9% in 2017, and lowest in mothers 25-34 years old (9.4% in 2017). Mothers who reported "other (non-Hispanic) ethnicity increased to 15.9% of mother who recently gave birth in 2015-2017, followed closely at 15.8% of Black (non-Hispanic) recent mothers.

Establishing a process to notify RAEs of postpartum depression and anxiety scores will help close the gap with health disparties and allow Medicaid patients to receive appropriate follow-up care with designated commuity providers. Establishing processes and relationships with community resources will allow mothers to receive the support they need. This process will connect mothers with local support systems and services that will not only benefit the mother, but also the baby. Untreated postpartum depression and anxiety can lead to "poor cognitive functioning, behavioral inhibition, emotional maladjustment, violent behavior, externalizing disorders, and psychiatric and medical disorders in adolescence (Slomian et al., 2019, para 6). The main benefit will be that the moms will be connected to services in the local communities through the Medicaid partners. This creates a stronger support network for both moms and ensures better outcomes for babies. In strengthening our communication with the local mental health providers via data sharing, care transitions and integrated mental health care delivery we can create a network to help ensure the safety and support of new mothers and their families. Our goal is to establish lasting relationships with community partners and stakeholders. As part of this commitment, Rose Medical Center will collaborate with HealthONE facilities to engage our community stakeholders on a bi-annual basis to provide updates, significant milestones, and next steps related to this intervention.

During our recent community partner and stakeholder meeting, feedback highlighted the importance of social needs screening to reduce readmission rates, referrals to primary care providers, and referrals for behavior health services. We will begin to work on these initiatives and schedule bi-annual sessions to ensure we are meeting the needs of our community partners and stakeholders and goals of the HTP.

Colorado Department of Public Health and Envirnment (2021). Vision: Visual Information System for Identifying Opportunities and Needs. Retrieved from https://cdphe.colorado.gov/vision-visual-information-system-for-identifying-opportunities-and-needs

Slomian, J., Honvo, G., Emonts, P., Reginster, J. Y., & Bruyère, O. (2019). Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. Women's health (London, England), 15, 1745506519844044. https://doi.org/10.1177/1745506519844044

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)
1. Randomized Control Trial (RCT) level evidence:

In 2018 the American College of Obstetricians and Gynecologists (ACOG) released a statement recommending that women should be screened for postpartum depression and anxiety once during the perinatal and postpartum periods with validated screening tools. In Colorado depression is the most common pregnancy complication. 1 in 9 women display signs and symptoms of depression in the perinatal or postpartum period (State of Colorado, 2021). Studies have shown undiagnosed postpartum depression and anxiety can increase the risk of unhealthy behaviors (Sidebottom et al., 2012). Such behaviors include a higher risk in the use of tobacco, alcohol and other illicit drugs, along with missed prenatal visits. The implications for the newborn include preterm delivery, low birth weight and other serious complications (Sidebottom et al., 2012). The Patient Health Questionnaire-9 (PHQ-9) has been validated to screen and detect postpartum depression in women (Sidebottom, et al., 2012).

Docherty et al. (2020) acknowledges that PPD is an important health concern. PPD is one of the most underdiagnosed obstetric complications in the United States (Earls, 2010 as cited by Docherty et at., 2020). Routine PPD and anxiety screening will catch mothers who are in need of services. Rose Medical Center started routinely screening postpartum women in the hospital setting with the PHQ-9 in 2019. This screening process has identified mothers who require a social worker consult before she is discharged home. At this point Rose Medical Center does not have a system in place to notify the RAE of positive screens. During the HTP journey Rose Medical Center will establish relationships with the RAE to notify and help new mothers receive help for positive PPD screens.

References

American College of Obstetricians and Gynecologists (2018). Screening for perinatal depression. Retrieved from https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2018/11/screening-for-perinatal-depression.pdf

Docherty, A., Najjar, R., Combs, S., Woolley, R., & Stoyles, S. (2020). Postpartum depression screening in the first year: A cross-sectional provider analysis in Oregon. Journal of the American Association of Nurse Practitioners, 32(4), 308–315.
https://doi.org/10.1097/JXX.0000000000000250

State of Colorado (2021). Pregnancy related depression. Retrieved from http://cdphe.colorado.gov/pregnacy/pregnacny-related-depression

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: ____ (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 aligns with other statewide initiative. First off, the Behavioral Health Taskforce aligns with Rose Medical Center's proposed intervention because of the identified challenge of access by providing specific resources and/or referrals. Accountability by establishing specific relationships for referrals and resources for identified patients; and Whole Person Care by addressing both physical and emotional health needs.

Next, the IT Roadmap focuses on data sharing. We plan to leverage an established process, CORHIO to share data and notify RAEs of referrals.

Lastly, HQIP has a Perinatal Depression and Anxiety Measure for 2021. Rose Medical Center's proposed intervention for HTP will align with HQIP and will fully support the four "Rs" of Readiness, Recognition and Prevention, Response and Reporting/Systems Learning.

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 routinely screens women for postpartum depression and anxiety, but does not notify the RAE of Medicaid patients who score at 15 or above on the PHQ-9. Throughout the Hospital Transformation Program, Rose Medical Center will establish partnerships to appropriately refer patients. 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.

Establishing a process to streamline Medicaid referrals for postpartum depression screens of 15 and above on the PHQ-9 will improve the continuum of care for this vulunerable population at Rose Medical Center. Throughout the HTP we will implement streamlined referrals, establish community partnerships and close gaps in the care for the Medicaid population. Thus leading to improving patient outcomes, improving patient experiences, lower health costs, and increasing collaboration with care transitions to meet the needs of this particular population.

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 routinely screens all postpartum women for postpartum depression and anxiety with the PHQ-9. A score of 15 and above triggers a consult by a liscenced social worker for a risk and needs assessment. This process will not change throughtout the Hosptial Transformation Program, but we will establish community partners for patients to follow-up with in an outpatient setting. Currently, the facility does not have established community partners to refer women to who score at or above 15 on the PHQ-9. Establishing partnerships with community partners and key stakeholders will be the area of focus for this intervention.

This intervention will advance the goals of the Hospital Transformation Program by improving the patient and their family's outcomes by ensuring timely integration of local mental health resources into the patient's plan of care. Our efforts with this measure in the HTP framework will help to prevent adverse outcomes for mother and their family, and will proactively limit the burden on an already stressed mental health system. These steps will help decrease readmission rates by connecting high risk patients with community resources. Furthermore, we are highlighting the collaboration among our community partners via data sharing, evidence-based care coordination and care transitions, integrated physical and behavioral health care delivery, and chronic care management.

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)

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.