CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

1570 Grant Street
Denver, CO 80203

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: Social Needs Screening and Resource Allocation

Develop a standardized process to identify Medicaid members upon admission and effectively screen for presence of social determinates. Further implementation will include collaboration with the local RAE by establishing an efficient notification system to alert the RAE that an at-needs patient has discharged.

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-CP1

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 will target the Medicaid members with the aim of identifying and addressing social determinants of health (SDOH). Medicaid patients who present positive with an identified social need will be referred to our Regional Accountable Entity (RAE). Currently, Valley view is utilizing the social needs screening tool sponsored by the Accountable Health Communities Model (AHCM). This model focuses on five core domains, which encompass housing instability, food insecurity, transportation problems, utility help needs and interpersonal safety.

Presently, the Valley View Case Management department takes the lead on screening patients for SDOH prior to discharge and participating in a referral network recently developed on the western slope called the Community Resource Network (CRN). Even though there exists a basic framework, we recognize that there are opportunities to enhance the current process through standardization and optimizing efficiencies to create a sustainable workflow. Valley View is considering the opportunity to leverage a more dynamic social determinate stratification tool, Carrot Health, to assist in identifying social needs that are not voluntarily self-reported by the patient and explore options to populate this social determinate data in the patient chart as well as in the HIE to benefit the expanded healthcare partners.

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 taking place across the appropriate settings. By collaborating with the RAE and other community partners including community-based organizations, the ultimate goal is to help the patient gain access to the appropriate resources and assist with removing the barriers that often distract and derail patients from the ability to focus attention to their health.

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)
CHNE process enabled Valley View to gain an understanding of community needs and perceived gaps at the local level. The results provided a platform from which Valley View was able to make informed decisions on priorities of interventions. Based upon our CHNE process, the following results were highlighted under the HTP planning with regards to bringing social determinates to the forefront:

- We recognize that being a community partner is more than the responsibility of providing safe hospital centric care, but assisting those in need reach their optimal health by addressing social factors that force other priorities over health.

- Top concerns for food insecurity and housing for our region were noted.

The CHNE highlighted implementing the AHCM tool and the challenges that were encountered during the early implementation period. Even though we have made some progress on this front, we recognize that the opportunity to benefit this population will be the connection that we make with the RAE and community resources. Valley View is an active participant in the local HIE (Quality Health Network) and most recently with the CRN in leveraging information exchange. If we can leverage the participation of the RAE within these same data sources, there is a great chance for future sustainability.

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)
Emerging Practice

The evidence base intervention selected entails providing a social determinants of health screen and referral to the target population with the intention of notifying the Regional Accountable Entity (RAE) of any positive screens. Screening for SDOH is becoming standard practice and literature suggests that addressing unmet social needs can lead to improved health and reduction in overall health care costs.

Unmet social determinants of health can contribute to medical illness, an increased risk of chronic diseases and unnecessary emergency department visits and hospitalization. Literature suggests that SDOH can account for up to 40% of individual health outcomes. Most commonly affected are low income populations who are more apt to use high cost emergency services for acute episodes (Thomas-Henkel & Schulman, 2017). Most organizations are aligned in the fact that screening for social determinates holds value. The difficulty comes with finding an efficient way to collect the data, and more importantly, creating efficient processes for hospital organizations to make referrals and communicate with community partners to ensure that the referral loop is closed with the patient receiving the needed resources.

Thomas-Henkel, C., Schulman, M., (2017) Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations. Retrieved from www.chcs.org

Link: https://www.chcs.org/media/SDOH-Complex-Care-Screening-Brief-102617.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

   ☐ Rx Tool

   ☐ Rural Support Fund

   ☐ SUD Waiver

   ☐ Health Care Workforce

   ☐ Jail Diversion

   ☐ Crisis Intervention

   ☒ Primary Care Payment Reform

   ☒ Other: CPC+ (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)
The Valley View organization with align this intervention with the ongoing initiatives identified above by integrating and assimilating the work already being performed by outpatient clinic departments, active committees and shared governance. Blending workflows for HTP into already established venues will minimize additional administration and staff burden that could arise from duplicative and siloed efforts

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)

Valley View has been actively using the ACHM screener on Medicaid patients in the inpatient and outpatient primary care settings due to participation in local and statewide initiatives. Our behavioral health providers and case management staff have established processes that can easily be assumed by new or onboarding staff members. This intervention will add additional processes to enhance our efforts while the foundation already established will support the success of the intervention.

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)
Even though there are pieces of this intervention already in place, we recognize that we have not optimized community collaboration. As referenced in our CHNE, we have recognized that there have been challenges as well as successes with the roll out of the AHCM tool. One being that the tool is not currently electronic in the inpatient space leaving opportunity for optimization. In addition, learning about the Carrot Health platform can expand upon the information that patients do not self-report. Through the CHNE, there are references made regarding our connection to the community and this intervention will assist us in exploring this connection and becoming close partners with the RAE.

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 Region 1 RAE	Regional Accountable Entity for Medicaid	Yes	Establishing standardized process for every facility in the region to report Medicaid members with positive social determine screenings
Colorado Hospital Association	Hospital Support and Advocacy	Yes	May assist in accessing patient social determinate data/risk
Quality Health Network	Health Information Exchange	Yes	May assist in accessing patient social determinate data/risk
West Mountain Regional Health Alliance	Regional Health Connector	Yes	May assist in accessing patient social determinate data/risk

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.