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: Care Coordination for SUD and Mental Illness

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)
A description of the intervention:

Our intervention proposal to achieve the SW-BH1 measure goals includes collaborating with case management to redesign a discharge process for all Medicaid patients 18 years or older

discharged from the hospital or emergency department with a primary of secondary SUD or mental illness. Our redesigned process will include a robust process of consenting for their approval to notify the RAE of their discharge. Some individuals might fall into state and federal statutes that allow notification without consent. This standardized consent process and applicable policies and procedures will be developed by an inter-disciplinary team including case management. This team will also collaborate with the RAE to form a process to ensure timely notification, within 24 hours after discharge, of these at-need patients' discharge and applicable information. The RAE's responsibilities include ensuring Health First Colorado members have access to primary care and behavioral health services, coordinating members' care and monitoring data to ensure members are receiving quality care. Through this coordinated effort we can ensure that patients with SUD or mental illness diagnosis receive continued care coordination through the RAE after discharge

Target Population:

This measure targets Medicaid patients 18 years or older discharged from the hospital or emergency department with a primary of secondary diagnosis of mental illness or SUD that have given consent to notify the RAE or for whom state and federal statutes allow notification without consent.

How the intervention advances the goals of HTP:

This intervention helps to promote the goals of HTP and the community by improving health outcomes for this vulnerable population through the integration of care across settings from hospital care to home care. Improving patient experience by ensuring those that want care receive care resources through the RAE. Supporting improved outcomes through coordinated care with community partners for those that suffer from substance use disorders and mental illness. Continuation of care post-discharge helps lower utilization of hospital services during health crisis by giving patients resources to care for themselves. Decreased inpatient and emergency room visits for these individuals can help reduce overall health care costs.

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)
According to our community health needs assessment from December 2018 the communities top health concerns include alcohol and substance use disorders and mental health issues. Therfore, connecting individuals after discharge to care coordination through notification of the RAE will

help to address our rural communities recongition of the need for these resources. Rural communities often lack the resources found in urban areas for continued care for patients in need of SUD or mental illness care which is certainly the case in our area. Providing Medicaid member patients with better health outcomes by collaborating with the RAE will help close this gap within 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)
(3) Best practice supported by less than RCT evidence

Continuity of care at patient discharge from the hospital is a critical aspect of high quality patient care. Highly reliable care requires close cooperation between care providers across organizational boundaries. Rural communities struggle more with poor behavioral health conditions compared to urban areas of the state. This aligns with stakeholder input which highlighted rural challenges in social isolation, closeness of services and geographic distance, transportation and other significant social determinant of health (SDOH) factors that contribute to need and difficultly in receiving substance abuse and mental health care.

Discharge planning units, with the help of case management staff, should assess patients for the need for discharge services, establish a consent processes, and coordinate with the RAE in an effort to provide needed resources. Such coordination of care is essential to ensure timely access to needed services. When discharge planning care fails to ensure speedy access to these services and continuity of care within the community, patients are at risk for failure to implement their treatment plans, homelessness, incarceration, or other adverse outcomes.

References

Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. National Academy of Sciences.

McGovern, M. P., & Carroll, K. M. (2003). Evidence-based practices for substance use disorders. The Psychiatric clinics of North America, 26(4), 991–1010. https://doi.org/10.1016/s0193-953x(03)00073-x

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)
Our intervention proposal will help align with the Goveners Affordability Road Map by helping paients high-quality mental health services in the least restrictive setting to promote the health while using state resources more effectively. These interventions now will help with the long term goals of decreasing health care costs for Coloradans.

These interventions will also support Colorado State Innovation Model (SIM) success by improving access to the right care, at the right time, in the right place for this target population by connecting them to care through the RAE.

Through the SUD waiver, by alerting the RAE of individuals that meet the criteria for substance abuse care, they are able to authorize inpatient and residential substance use disorder treatment stays as part of administering Health First Colorado's capitated behavioral health benefit.

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)

Our case managers and crisis team have been a valuable resource when facilitating a coordination of care and resources post discharge for our at-need patients. There participation in coordinating with the RAE and the facilitating the consent process will help support the success of this 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)

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)
Regional Accountable Entity – Region 1	Coordination of Care	No	The RAE will receive patient information that fall into the target population in order to coordinate primary and behavioral health care upon discharge from the hospital.

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.