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: Reduce Hospital Readmissions

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-RAH1
2. 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 addresses Reducing Avoidable Hospital Readmissions for Medicaid patients between 18 – 64 years of age with acute inpatient stays during the measurement year

that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission (SW-RAH1). This intervention also addresses reduction of 30 day readmissions for high frequency chronic conditions (CP1). This intervention will also enhance compliance with the Intervention for SW-BH1 which addresses the reduction of hospital readmissions for eligible patients with a diagnosis of mental illness or substance use disorder (SUD) discharged from the hospital or ED through collaboration and communication with the RAE.

This intervention will enhance the overall health and well being of the targeted populaton by enusuring appropriate care in the appropriate settings thorugh reduction in hospital readmissons and increased collaboration with community organizations and agencies to enhance patient care quality and thereby decrease Health First Colorado's overall costs of care.

Description of intervention: Our implementation plan will include:

1. Engagement with the RAE and relevant community partners to create collaborative discharge planning processes that intentionally match available resources to appropriate segments and/or risk profiles of the eligible population. We intend to use our Health Information Exchanve partner CORHIO to assist in the sharing of medical information with the RAE and other necessary community partners.

2.Integrating current readmission risk stratification tools such as the HCA Total Readmission Expert (TREX) predictive readmssion risk program to assist in identifying patients who are at risk of post discharge complications that may lead to a hospital readmission. This risk stratification tool automatically populates the case management worklist for all patients. TREX is also used in MultiDisciplinary Rounding (MDR) to guide discussions with providers regarding specific readmission risks and to devise actions that can mitigate these risks. Case Management Staff will use TREX to identify their highest risk patients and collaborate with their RAE's and community partners to provide the resources and critical follow up care this population needs.

3 Incorporating other risk stratification tools as appropriate based on patient needs to link the patients to appropriate post acute care providers through referrals and integrate this into our electronic medical record documentation.

3. Support of innovative technology srategies, such as CORHIO and HealthONE Patient Keeper, to improve communication between Primary Care Providers and Hospital Providers.

4. Enhancement of the Discharge Planning process to ensure that the plans are developed along with the patient and family and are in accordance with the patient/family wishes and are feasible with patient's psychosical, educational and financial abilities.

5. North Suburban Medical Center participates in the Bundled Payment Care Improvement Advanced initiative (BPCI-A). Under the bundled payments model (which only focuses on Medicare recipients) HCA has developed a Plus Care Network which consists of high quality post acute care providers. Plus Care Network providers have entered into contractual agreements with post acute providers to ensure that they will continue to provide quality care for our patients. This quality of post acute care will lead to decreased readmissions across all patients, including our most vulnerable population, Medicaid recipients.

6. Engagement in enhanced collaboration with our community partners via data sharing and analytics, evidence-based care coordination and care transitions, integrated health care delivery, and chronic care management.

Target Population:

Any Medicaid patient between 18-64 years of age with acute inpatient stays. This intervention will be applied across all populations at North Suburban Medical Center .

How this intervention advances the goals of HTP:

We believe this intervention will advance the goals of the Hospital Transformation Program by decreasing hospital readmissions for patients through risk stratification for readmission potential and greater effectiveness and efficiencies in discharge plans. This will reduce cost of unnecessary readmissions and improve patient outcomes by ensuring integration of care is occurring across the appropriate settings.

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)

North Suburban Medical Center is located in the Northern part of Adams County. The core population includes Medicaid patients with underlying chronic illnesses which include medical and behavioral health conditions, substance use disorders, and homelessness and transportation limitations. The CHNE revealed that North Suburban Medical Center serves a population who are identified as high-risk as a result of these underlying issues. These high risk patients are often without access to primary care due to education levels preventing understanding of how to access Primary Care, transportation issues, family and work obligations etc. This results in poor health management and enhanced risk of chronic underlying disease processes going untreated over periods of time.

The CHNE assessment also documented the following information about the North Suburban Medical Center population:

* North Suburban Medical Center serves a population of patients who don't have access to a primary care and/or specialty services due to very few providers accepting Medicaid and the lack of after-hours or weekend services.

* individuals experiencing homelessness including a greater than 66% increase above the Denver Metro area percentage of children and adolescents

* patients with undiagnosed or untreated behavioral health concerns that are driving their care utilization and poor health

*High emergency department utilization, or “mis-utilization” such as using emergency departments for primary care services

* children and adolescents experience homelessness in the NSMC area at a greater than 66% increase above that same population in the Denver Metro area.*

* a larger than the Denver Metro average of patients of Hispanic ethnicity (27.4% compared to 22.3%)

* higher than the Denver Metro average of residents are living below 200% of federal poverty level (35.1 % compared to 31.9%)

* higher than average percent of disabled residents (9.9% vs 9.2%)

* lower percentage of patients with a high school diploma (10.8% compared to 8.6 %)

* higher than average percentage of non citizens (8% vs 7.4%)

* transportation to follow-up care was identified as a challenge for our population

* This population may also experience food and housing insecurity and may be struggling with unemployment.

* Compared to the Denver metro region, NSMC’s service area population suffers from higher rates of overweight or obese adults at 66.5 %. Relatedly, this population experiences more hospitalizations related to stroke, and heart disease.

* The senior population in particular was identified as a vulnerable population that is frequently lacking in resources and due to their frail and unique medical needs, often lacking the tools needed to navigate the complex health system thus leading to readmissions.

* Pregnant and birthing mothers were identified as high risk for not getting their overall health needs met; more than 2 out of 5 births in the North Suburbab Medical Center area were delivered to overweight or obese mothers.

The CHNE process noted that these above factors align with higher risk for readmission.These high-risk patients drive a high utilization of hospital admissions due to their untreated medical condition, lack of primary care and lack of medication adherence. This leads to poor health management and enhanced risk of chronic underlying disease processes which remain untreated for long periods of time. High risk patients have longer length of stays due to higher acuity for management of ongoing medical conditions. Evidence shows that decreasing over-utilization by high utilizers requires a multi-faceted approach which includes addressing social determinants of health. The North Suburban Medical Center population will benefit from increased navigation of

services, increased community resources and management of both social/behavioral and medical needs.

The proposed intervention aligns with the CHNE as it will will provide North Suburban Medical center the opportunity to identify our patients at higher risk for readmission which will in turn enhance our processes to refer these patients to local community partners to address any deficits which directly impacts their lives, well-being, and health.Our interventions will aim to address these core needs of the community and the Medicaid population we serve.

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 Practices support by less than RCT evidence:

Hospital readmissions are costly for payors, patients and hospitals. Methods to decrease and avoid hospital readmissions have been studied extensively for many years.

In 2001, the Institute of Medicine (IOM) reported that patients do not receive adequate information on how to care for themselves after hospital discharge, when to resume activities, what medication side effects to look out for, and how to get answers to questions after discharge. This can result in worsening of medical conditions for the patient. These patients may then be readmitted to the hospital. The IOM stated that nearly 20 percent of Medicare beneficiaries discharged from the hospital were readmitted within 30 days; three-quarters of these readmissions cost $12 billion per year.

The Hospital Readmissions Reduction Program (HRRP) was created by CMS in 2010 under the Affordable Care Act to reduce the number of preventable Medicare readmissions. CMS launched HRRP in fiscal year 2013. Financial penalties were given to hospitals that had high rates of 30 day readmissions for patients who had been hospitalized with pneumonia, heart attack, or heart failure.

In 2011 the Association for Healthcare Research and Quality (AHRQ) reported that Medicare patients had the largest share of total readmissions (55.9%) and associated costs for readmissions (58.2%) of any payor. Medicaid had the second largest share of total readmissions (20.6%) and

represented a lower share of associated costs (18.4%). Overall, readmissions resulted in hospital costs reaching $41.3 billion for patients readmitted within 30 days of discharge

In a report by Health Affairs in 2011, ineffective care transitions following a hospitalization increased the rates and costs of hospital readmissions and accounted for $25 to $45 billion in wasteful spending

The Joint commission believes that lack of adequate communication leads to ineffective care transitions from the hospital to post-acute care or home settings. This lack of adequat communication can lead to hospital readmisisons.

A Patient Experience study showed that failing to include patients in the discharge process results in higher hospital readmission rates. Patients who reported that they were not involved in their care during the original hospitalization were 34 percent more likely to experience a readmission. In addition, patients who did not report receiving written instructions for discharge care were 24 percent more likely to be readmitted.

HCA Healthcare has created Total Readmission Expert (TREX), a data driven tool to predict a patient's risk for readmission within 30 days. This tool utilizes data from 11 sources including: length of stay, chief complaint code, admission type (inpatients only), emergency admission, attending and admitting physician specialty, procedure code and severity, patient height, weight and BMI, pt gender and age, previous visits in any HCA Healthcare facility, and previous ED visits in any HCA Healthcare facility. This risk stratification tool populates the case management worklist of patients automatically for all patients.

North Suburban TREX is also used in interdisciplinary rounding to guide discussions with providers regarding specific readmission risks, and to devise actions that can mitigate these risks. Case Management will use TREX to identify their highest risk patients and collaborate with their RAE's and community partners to provide the resources and critical follow up care this population needs. Medical Center plans to continue to reduce our readmission rates overall. We will incorporate patient and family education about continuing care into our discharge processes.

CITATIONS:

1. Health Affairs, Health Policy Brief, Improving Care Transitions, Rachel Burton, September 23, 2012

   https://www.healthaffairs.org/do/10.1377/hpb20120913.327236/full/

2. RevCycle Intelligence, Value Base Care News, Jacqueline LaPointe

https://revcycleintelligence.com/news/3-strategies-to-reduce-hospital-readmission-rates-costs

3. The Joint Commission, Hot Topics in Healthcare, Transitions of Care

https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/hot_topics_transitions_of_carepdf.pdf?db=web&hash=CEFB254D5EC36E4FFE30ABB20A5550E0

4. Agency for Healthcare Research and Quality (AHRQ) Statistical Brief, April 2014

https://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf

5. Patient Engagement HIT, Patient Engagement in Follow-Up Reduces Hospital Readmission, Sarah Health. August 2017

https://patientengagementhit.com/news/patient-engagement-in-follow-up-reduces-hospital-readmission

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)

To focus on Reducing Avoidable Hospitalization for eligible patients, North Suburban Medical Center has identified the importance of coordination of care with Colorado statewide initiatives.

Affordability Roadmap - Communication of patient information to a patient's primary care provider enables that transfer of key hospital information to prevent conditions from worsening and reducing possible readmissions.

Behavioral Health Task Force - North Suburban Medical Center's proposed intervention is designed to address the Taskforce's 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.

IT Road Map - Through continued and enhanced use of CORHIO for communication of healthcare episodes for current patients and to ensure coordinated communication with the RAEs, North Suburban Medical Center will be benefit from specific efforts of Colorado's Digital Health Innovation and the Office of eHealth Innovation.

Accountable Care Collaborative – Continued and enhanced communication and collaboration with the RAE for discharge planning and services is critical to safe discharge handoff in order to strengthen the coordination of services and further assist in efforts to reduce avoidable hospitalizations.

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)

North Suburban Medical Center holds MultiDisciplinary Rounds (MDRs) daily on all patient care units. These Rounds are held in an effort to enhance discharge planning by ensuring a collaborative process of planning across all disciplines to provide for safe, effective, and patient centered discharge plans. These collaborative discharge plans will lead to decreased readmissions, enhanced patient safety and decrease in utilization of healthcare services and dollars.

North Suburban Medical Center has held High Dollar/High Length of Stay Rounds for over 20 years. These Rounds are intended for review and discussion of patients with Length of Stay greater than 8 days, and/or Total Charges above $150,000 and for any uninsured patient. These rounds employ problem solving across the areas of patient safety, patient needs for continuing care, financial resources, and eligibility for programs to assist in payment of current and future care.

Historically the hospital has collaborated well with Skilled Nursing facilities (SNF), Long Term Acute Care providers (LTAC), Home Healthcare Agencies (HHC) and Inpatient Rehab facilities

(IRF). These existing relationships with Post Acute Care community providers is now enhanced through the HCA Plus Care Network of providers (see section 3).

North Suburban Medical Center intends to extend our collaboration for post-acute care services with the RAE to ensure that follow up Primary Care Provider (PCP) visits will be arranged and maintained and that patients have access to necessary medications and treatments.

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 patients who have complex medical issues. The enhances relationships with our community providers as well as Colorado Access/RAEs and will allow for better collaboration on patients 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 develop timely patient and family focused discharge plans that incorporate the patient's needs with interdisciplinary input, taking into consideration the patient's historical information.

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

D. Care coordination activities designed to ensure sustained patient access to care and decresed reduction in risk for future hospitalization;

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

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

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)

North Suburban Medical Center's overall all cause readmission rate remains steady at between 7 and 9%. This is consistent with readmission rates within the HealthOne system and typically one or 2 percentage points below that HealthOne average.

As mentioned in #7, North Suburban Medical Center maintains long held practices of a MultiDisciplinary approach to Discharge Planning through its MDRs and High Dollar/High Length of Stay Rounds. These measures employed currently will decrease our readmission rates over time by incorporating the TREX scores into the rounds and implementing safer and more effective discharge plans for our patients.

Additionally the hospital's Utilization Management Committee has reviewed data on all 30 day all cause readmissions (SW RAH-1) as well as 30 day readmissions for high risk diagnoses (CP1). This committee is prepared to dig deeper into reasons and causes for readmissions in an effort to identify causes and prevention measures to further decrease the readmission rate.

As mentioned above, North Suburban Medical Center's Case Management staff maintain excellent working relationships with providers of HHC, SNF, LTAC and IRF. There is sharing of patient information as well as communication about best practices.

North Suburbab Medical Center intends to enhance our relationship and information sharing with our Colorado Access partners, the RAEs (SW-BH1 and COE1)

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.