



CHASE

Colorado Healthcare Affordability and
Sustainability Enterprise

1570 Grant Street
Denver, CO 80203

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: The NATE Tempo Tool, barrier rounds and the walking program
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-PH1: Severity Adjusted Length of Stay (LOS)
 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)

Description of Intervention: The scientifically proven interventions selected by HCA hospitals to reduce length of stay include, daily barrier rounds, an electronic tracking system that identifies barriers in real time (NATE), and a walking program to reduce hospital related debility. These interventions will be implemented hospital wide and will focus on all patients regardless of their



insurance. This program will identify both medical and social barriers to discharges upon admission, which will allow the treatment team to address these barriers at the beginning of the patient's care. Thirty percent of Swedish Medical Center's patients have Medicare and are some of the most vulnerable individuals who are at risk for readmissions and longer hospital stays. We are confident that these interventions will pay closer attention to this population's medical and social needs and as a result provide better care and reduce unnecessary hospital stays.

The NATE Tempo Tool, designed by Health One, is designed to assist facilities in improving patient throughput, identifying discharge barriers and improving clinical efficiency and discharge planning. The tool auto-populates key information from the hospital's electronic documentation system and has some predictive modeling capabilities. This tool allows for those involved in a patient's care plan to update information in this tracking system as a way to communicate to all members of the treatment team in real time. During morning barrier rounds, the Charge Nurse on the units will update the tracking system based on what the goals and barriers are for that day. With that information the team and patient know what the expectations will be in order to discharge home on the expected day of discharge.

Target Population: All inpatients at Swedish Medical Center

How the intervention advances the goals of the HTP: Another addition to both NATE and barrier rounds that is being implemented in HCA hospitals to reduce post-acute needs and length of stay is the walking program. Research has shown that walking programs in hospitals have reduced hospital acquired infections, post-acute care needs, and overall reduced length of stay. During barrier rounds the team will identify at risk patients who will need attention paid to their mobility during hospitalization and this will be tracked in NATE. This will alert the patient's charge nurse throughout the day to walk in order to prevent physical decompensation during their hospital stay, and so that they can return to their prior living situation once medically ready to discharge. We believe these interventions will advance the goals of the Hospital Transformation Program by improving communication between medical interdisciplinary team, better the patient's experience, improve health outcomes, improve provider experience, and reduce the cost of care.

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)

Participating HCA Hospitals service a highly diverse Medicaid population who are identified as high-risk as a result of socioeconomic status, education level, language barriers, access to



resources, serious behavior health disorders, substance use disorders, and/or significant physical health concerns. The Medicaid population at Swedish Medical Center faces discharge barriers which put them at a higher risk for longer stays in the hospital and higher readmission rates. By focusing on the patient's barriers early in their stay through the tracking system, NATE, we can identify the patient's needs early enough to start planning early in their admission. The walking program will also greatly benefit this population by maintaining and/or increasing their activity level and ability to complete activities of daily living prior to discharge.

One of the greatest barriers we face with our diverse Medicaid population is that rehab programs in a skilled nursing facilities are not available to them, which is directly related to greater lengths of stay and social readmissions. Our treatment team cannot safely discharge patients home when they require daily physical therapy. This must be provided in the hospital until they can safely discharge home with home health care. Additionally, we are unable to provide our Medicaid population with inpatient substance use programs. The new barrier documentation system, NATE, and our structured walking program will identify these barriers on admission and focus on this population's discharge needs upon admission to the hospital. We have multiple stakeholders (home health agencies, skilled nursing facilities, and acute rehabs) who are committed to our case management team and who have agreed to take part in the Hospital Transformation Program to better serve Medicaid patients in the 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)

1 & 2

Unnecessary hospitalization often leads to patients deconditioning, hospital acquired illnesses, increased risk for mortality, and financial risks to both the patient and the hospital. Hospitals worldwide are focusing on increasing communication between interdisciplinary teams by developing electronic systems that track length of stay and barriers to meet that date. There is also a major focus on increasing mobility for patients who are identified as at risk for deconditioning, which correlates directly to increased length of stay. This comprehensive review of evidence based studies supports the interventions that Swedish Medical Center is using to reduce length of stay in order to ensure better outcomes for both the patient and the hospital.



Based on the amount of research done on these specific programs, we are confident in our decision to implement these interventions into our daily assessment and treatment with patients in order to increase satisfaction and reduce length of stay.

Hospital tracking systems, like NATE, are used to paint the picture of the patient's case, including medical, physical, mental, and social issues, which might play a part in their course of treatment and hospital stay. In a needs assessment conducted by Patel, Morduchowicz, and Mourad, found that the four biggest barriers to early discharge include 1) lack of communication between nurses, case managers, and teams about discharge planning; 2) obtaining home services, equipment, and oxygen first thing in the morning; 3) arranging transportation to facilities earlier in the morning, and 4) communicating discharge expectations with patients and family members. This same study found that by developing and implementing a web-based dashboard that provides real-time discharge by noon, they had a decrease in average length of stay by .28, which is significant (2017). California HealthCare Foundation argues that in order for this program to be effective and reduce length of stay, information needs to be entered as the patient admits to the emergency room or for surgery and is updated in real time throughout their hospital stay (2011).

Another study took the barrier tracking program a step further and recommended that the patients have a tracking system attached to them or their bed, like hospital equipment, in order for the nurse and following treatment team to know that this patient is in a procedure so the team can start preparing for the patient's next step toward discharge (Lewis, 2000). For example, if the patient is just needing a stress test in order to be discharged, the nurse will be alerted as the patient is being taken to the procedure and when the patient's procedure is completed, so that the nurse and others involved in the patient's discharge can focus on the remaining barriers that affect them discharging. To the reader this may sound extreme, however, Susan Lewis (2000), puts this in perspective by using CSC calculation based on CDC data on average length of stay in the United States, they conclude that reducing the average length of stay by four hours is equivalent to increasing available hospital beds by ten. The progressive barrier tracking systems that hospitals are creating can be accustomed to the patient population they serve to better fit the needs of the patient's and their environment.

Fortunately, there was more evidence in studies that showed positive outcomes to electronic systems that track barriers to discharge than there were studies with no changes or increase in length of stay. In one study, a VA Hospital in Seattle Washington interviewed a treatment team in order to identify the main drivers behind length of stay in their hospital and reviewed discharges for 6 weeks as a baseline assessment. Their intervention included structured multidisciplinary rounds with an electronic tool that was developed to highlight critical information on each patient consistently (Meo, Wilson, Powers, Magbual, and Miles, 2018). The goal of the electronic system was to update the team in real time, what the expected discharge date was and what needs to be achieved in order to hit to that goal. The outcome of this study showed a decrease in length of stay by 1.4 days and an improvement of 21.1% (Meo, Wilson, Powers, Magbual, and Miles, 2018). These are just a few examples of the studies reviewed for development of our interventions.

In addition to barrier rounds and a system that tracks barriers in real time, research shows that walking programs in the hospital with vulnerable patients also reduces length of stay. A comprehensive review of inpatient mobility programs geared towards vulnerable individuals who are at risk of decompensation during hospitalization was completed to recognize the different walking programs that are being used at institutions, their effectiveness on length of stay and



patient care, and barriers or limitations to a successful mobility program. There are plenty of studies on different mobility programs around the country and their effectiveness. We are confident that if Swedish Medical Center adopts some of the interventions used in these walking programs, our institution will see a major reduction in length of stay and an increase in patient and staff satisfaction.

A hospital mobile program focuses on patients who are at a higher risk of decompensating during hospitalization and ensures that this population receive more attention to their mobility while inpatient. A patient's risk is determined by their age, comorbidities, current diagnosis, hospital course, and other factors. A walking team typically includes: Physical and Occupational Therapists, nurses, and nurse's aids (Wood, Tschannen, Trotsky, Grunawalt, Adams, Chang, Kendziora, and Diccion-MacDonald, 2014). The different studies used for this review did not have similar program structure but were similar in the activities they were measuring, such as getting out of bed into a chair several time a day, walking at least three times a days, and performing range of motion in bed frequently though out the day (Wood, Tschannen, Trotsky, Grunawalt, Adams, Chang, Kendziora, and Diccion-MacDonald, 2014). We found it surprising to see this amount of success with a walking program without a structured program used in hospitals across the nation.

Not all studies found that a walking program decreased length of stay, however, they all discovered that there were other benefits that led to many hospitals continuing the program well after the study's ended. An interdisciplinary team at a hospital in Iowa developed and piloted an early mobility program on their surgical unit over a three month period, capturing 521 patients for their study. Their goals were to reduce length of stay, reduce the number of falls on this unit per month, reduce readmission rate within 30 days of a patient discharging, and reduce hospital acquired pressure ulcers. Although their length of stay slightly increased and their number of pressure ulcer incidents remained the same, they saw a major decrease in the number of falls on the unit and a major decrease in readmissions (Wood, Tschannen, Trotsky, Grunawalt, Adams, Chang, Kendziora, and Diccion-MacDonald, 2014). Another positive outcome to this study, and others alike, is that there was an increase in patient satisfaction, and both staff and the patients felt that this program was beneficial to their care (Wood, Tschannen, Trotsky, Grunawalt, Adams, Chang, Kendziora, and Diccion-MacDonald, 2014).

Here are several other examples of studies completed that show evidence that walking programs reduce length of stay. First, a quasi-experimental nurse driven mobility program used a physical mobility algorithm and gait belts to focus on patients ambulating in the first 72 hours of admission in the intensive care unit (ICU). This study found that only 6.2% of ICU patients and 15.5% of medical patients ambulated prior to the study, compared to 20.2% of ICU patients and 71.8% of medical patients ambulated in first 72 hours after this study (Drolet et al, 2013). Another study that conducted a nonequivalent control-group study of 50 hospitalized older adults and found for the treatment group that ambulated 3.12 times a day versus the control group that ambulated 2.44 times per day had a reduced length of stay by 3.76 days (Padula, Hughes, and Baumhover, 2009). One more study found a decrease in length of stay by 2 days when they increased the patients walking activity by 600 steps from the first to second day of hospitalization (McCullagh, Dillon, Dahly, Horgan, and Timmons, 2016). It's surprising that with all of this evidence that walking programs reduce length of stay and increase satisfaction among patients and staff, that more hospitals don't implement a similar program.

References:

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing.
www.colorado.gov/hcpf



Drazen, E., Rhoads, J., and California HealthCare Foundation. (2011). Using tracking tools to improve patient flow in hospitals. NLM 101567187.

Drolet A., DeJulio P., Harkless S., Henricks S., Kamin E., Leddy E. A., . . . Williams S. (2013). Move to improve: The feasibility of using an early mobility protocol to increase ambulation in the intensive and intermediate care settings. *Physical Therapy*, 93, 197-207. doi:10.2522/ptj.20110400

Lewis, Holly S. March 2000. "Understanding Patient Flow." *Decision Line* 31 (2); 8-10.

Mccullagh, Ruth & Dillon, Christina & Dahly, D & Horgan, Frances & Timmons, Suzanne. (2016). Walking in hospital is associated with a shorter length of stay in older medical inpatients. *Physiological Measurement*. 37. 1872-1884. 10.1088/0967-3334/37/10/1872.

Meo N, Paul E, Wilson C, Powers J, Magbual M, Miles KM. Introducing an electronic tracking tool into daily multidisciplinary discharge rounds on a medicine service: a quality improvement project to reduce length of stay. *BMJ Open Qual*. 2018;7(3):e000174. Published 2018 Jul 21. doi:10.1136/bmjopen-2017-000174

Padula C. A., Hughes C., Baumhover L. (2009). Impact of a nurse-driven mobility protocol on functional decline in hospitalized older adults. *Journal of Nursing Care Quality*, 24, 325-331. doi:10.1097/NCQ.0b013e3181a4f79b

Patel H, Morduchowicz S, Mourad M. Using a systemic framework of interventions to improve early discharges. *Jt Comm J Qual Patient Saf* 2017; 43:189-96. 10.1016/j.jcjq.2016.12.003

Wood, Winnie, Tschannen, Dana, Trotsky, Alyssa, Grunawalt, Julie, Adams, Danyell, Chang, Robert, Kendziora, Sandra, Diccion-MacDonald, Stephanie, CE: A Mobility Program for an Inpatient Acute Care Medical Unit, *AJN, American Journal of Nursing*: October 2014 - Volume 114 - Issue 10 - p 34-40. doi: 10.1097/01.NAJ.0000454850.14395.eb

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 identify 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)

On November 8th, 2017, the Colorado Governor's office approved Colorado's Health IT Roadmap, which aims to reduce healthcare costs, provide better care, and improve health care for all of Colorado. The three biggest initiatives that intersect with the statewide measure to decrease length of stay, includes, increasing communication among stakeholders, improve consumer engagement, empowerment and health literacy; and develop approaches for making health analytics accessible and affordable. While this plan doesn't directly impact our interventions to reduce length of stay, it does have a major influence on discharge planning with our community partners and our patients. First, having access to patients past medical records in real time will allow the treatment team to better identify past treatment, past barriers, and possible new barriers. It will reduce trial and error and allow us to provide better continued care. Then, this also streamlines referrals to our stakeholders and those involved in the patients past and future care, which reduces the chances for acute care readmission. Last, allowing patients to have access to their medical records electronically allows them to better manage their appointments and medications. Our patients with Medicaid are typically more vulnerable and have an increased risk of readmission, we feel that by improving connection and communication can promise them better outcomes.

Another statewide initiative that correlates with reducing hospital length of stay is the Accountability Care Collaborative. The goal of this program is to improve member health and reduce costs by strengthening coordination of services between health care systems and Medicaid participants. Seven Regional Accountable Entity contracts have been created based on services area to ensure that Medicaid members have access to all necessary services once discharged from a hospital. Care Coordinators through the assigned RAE will connect the patient to community resources, help them understand their benefits, help them get behavioral or physical health services, find primary care providers or specialist, schedule transportation for medical and behavioral health appointments, coordinate communication between the different providers, give patients information about health and wellness topics, and help them understand the medication they are taking. By having this professional assist the patient in navigating the many systems in the community, the patient's treatment team feels more secure about discharging the patient's home on the day they are medically stable.



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)

Swedish Medical Center has practiced different ways of doing morning rounds with physician and treatment team, however, many of these programs were not successful, and therefore we continue to modify the structure of rounds and communication and action plan regarding patient barriers. Our barrier electronic documentation system is new and went live June 2020. All units are officially using this system but because the program is so new we are constantly making changes that fit our hospitals needs to better track barriers. Some units at Swedish started the walking program without great success in the past, however, this is an area that Health One sees as necessary and for that reason this will be developing in the coming months and eventually tracked.

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)

As mentioned, hospital rounding has been practiced at Swedish Medical Center for many years, however, rounding alone has not given us the outcome we are wishing for and therefore our corporate office has created a documentation system to be used in addition to rounds to track barriers. Our barrier documentation system is new and went live June of 2020. We are still making changes to this program to better fit the needs of our patients and hospital. The walking program has been recommended to nurses in the past, however, there has never actually been a program in place. NATE allows the treatment team to add the walking program to the daily barriers for vulnerable patients. This also allows us to track and measure the outcomes of this program.

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](#).

