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: Social Needs Screening and Notification

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: Social Needs Screening and Notification

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 World Health Organization (2020) defines "social determinants of health" as the conditions in which people are born, grow, live, work, and age. Addressing social determinants of health can improve compliance with healthcare treatment regimens, reduce cost of care, and improve

outcomes. Solely treating a patient's acute health care needs without a more holistic consideration of their situation can create a cycle of readmissions and ongoing health care crises.

According to the American Academy of Family Physicians (AAFP), in order for the medical community to have a significant and lasting impact on the health of their patients and communities, we must address the needs of patients outside the clinic walls. Medical providers must implement programs to identify and attend to these social factors depending on the specific needs of the patient population, the ability of the practice to assess these needs, and the availability of community resources.

Hospital systems are in a unique position to reduce the cost of healthcare by including social determinants of health in the treatment planning process. In order to accomplish this, hospitals will need to assess for at least five key domains of social determinants including housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety.

To address this measure, Rose Medical Center will:

1. Enhance the electronic medical record to capture screening of patients for social determinants of health.

2. Utilize an evidence-based or best practice community resource tool such as findhelp.org (formerly Aunt Bertha) or the Neighborhood Navigator (navigator.aafp.org).

3. Develop a technology-based solution to transmit captured SDOH/identified needs to appropriate community partner and patient's RAE.

4. Collaborate with the RAE (regional accountable entity) to determine to what level of social determinant need should trigger a transmission of the data captured.

Rose Medical Center's target population for this intervention is:

All RMC patients admitted inpatients that have Medicaid as their primary payor.

The intervention aligns with several HTP objectives. First, it aims to enhance partnerships across local/community agencies and hospital systems. Second, it will impact and likely reduce avoidable hospital utilization. Third, the intervention will likely impact quality patient outcomes and satisfaction through the care redesign.

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)
Based on the CHNE (community health and neighborhood engagement) process it was found that:

Rose's service area population is slightly younger, more diverse, earns less, and is less educated. People in the area are also more likely to be non-US citizens.

More than a third of service area residents are living below 200 percent of federal poverty level (36.9 percent).

About 3.2 percent of service area residents are unemployed, compared to about 3.1 percent of metro Denver residents.

Like all residents of the Denver metro region, rent is a major expense for families living in Rose's service area. Almost a quarter (23.5 percent) of service area families are using at least half of their household income to pay for rent. That's similar to the 24.1 percent of metro Denver residents facing the same rent burden.

Residents of Rose's service area have fewer years of education than the metro Denver population. For example, 11.5 percent of service area residents have no high school diploma or equivalent, compared to 8.6 percent of metro Denver residents. And 13.6 percent of service area residents hold a post-graduate degree, compared to 16.0 percent of metro residents

Historically, individuals who are of lower income tend to have worse health outcomes and decreased life expectancy compared to those more affluent (Colorado Law & Policy Center, 2018). 30% of Colorado children live in a household at or near the poverty level (Colorado Coalition for the Medically Underserved). Poverty, food insecurity and interpersonal safety may lead to negative health outcomes later in life (Colorado Children's Healthcare Access Program, 2020). Research shows that individuals with unmet social needs tend to have problems managing chronic health issues and utilize the emergency department frequently (Henkel & Schulman, 2017).

The proposed intervention will provide Rose Medical Center with the opportunity to consistently assess for social needs, capture our most vulnerable patients via the standardized assessement process, and refer our patients to local community partners to address any deficits which directly impacts their lives, well-being, and health.

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 practice supported by less than RCT evidence and Emerging practice.

Literature describes social determinant screening as a developing practice which fosters the opportunity to provide quality healthcare and improve health outcomes. Population health management is described as a comprehensive approach of addressing the health and social determinants beyond the care setting (Devereaux & Zilz, 2018). There is also evidence that formal partnerships between healthcare organizations and social services result in cost savings and better health (Taylor, et al; June 2015) (Colorado Prevention Alliance, 2017).

Screening for social determinants of health is recommended or being considered for recommendation by the American Academy of Pediatrics, American Academy of Family Physicians, and American College of Obstetricians and Gynecologists (Davidson,2019).

Social Determinants of health are not just humanitarain acts. Studies consistently show the direct correlation between the connection of services for our basic human needs to the significant reduction in healthcare costs. Wellcare Health Plans and the University of South Florida published a study showing a 10% reduction in health care costs for their subjects connected to social services in the community compared to their control group of members who were not connected to any services.

Citations:

Colorado Center on Law & Policy.(2018). Income & health disparities: Poverty is a health issue. Retrieved from http://cclpvitalsigns.org/income-health-disparities-poverty-is-a-health-issue.php

Colorado Children's Healthcare Access Program. (2020)Data snapshot. Retrieved from https://cchap.org/our-focus/health-disparities/

Colorado Prevention Alliance. (2017). Social determinants of health and the impact on health and healthcare. Retrieved from http://www.coloradopreventionalliance.org/assets/cpa-sdoh-overview-final.pdf

Davidson, K., McGinn, T. (2019). Screening for social determinants of health: the known and unknown. Jama 2019. DOI: 10.1001/jama.2019.10915

Devereaux, D., Zilz, D. (2018). Population health management: A community imperative. American Journal of Health-System Pharmacy, 75(2), 46-48.

Expenditure Reductions Associated with a Social Service Referral Program. Retrieved from https://www.liebertpub.com/doi/10.1089/pop.2017.0199

Lagasse, J. (n.d.). Social determinants shown to reduce healthcare spending. Retrieved from http://www.healthcarefinancenews.com/news/social-determinants-shown-reduce-healthcare-spending

Social Determinants of Health: Guide to Social Needs Screening. Retrieved from https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-guide-sdoh.pdf

Thomas-Henkel, C., Schulman, M. (2017). Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations. Retrieved from https://www.chcs.org/media/SDOH-Complex-Care-Screening-Brief-102617.pdf

World Health Organization. (2020). Social determinants of health. Retrieved from https://www.who.int/teams/social-determinants-of-health#:~:text=The%20social%20determinants%20of%20health%20(SDH)%20are%20the%20conditions%20in,the%20conditions%20of%20daily%20life.

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 proposed measure aligns with Affordability Road Map which outlines the Blueprint to End Hunger and increase access to healthy food. Food instabilty is one of the domains of the social determinants of health and our proposed intervention will address food insecurity.

Two goals for the accountable care collaborative is to combine the management of physical and behavioral health under one accountable entity and to strenghten the coordination of services among service providers for Medicaid recipients. Under the ACC, RAE's (regional accountable entities) were contracted out, which Rose Medical Center currently works alongside, and will continue to work alongside for the HTP interventions described above. Strenghtening our coordination of services together will assist in the efforts of reducing avoidable hospitalizations, reducing length of stay and improving overall patient outcomes. The collaboration with our RAE's will also ensure a safe discharge handoff and continuation of much needed services for underserved members of our community.

7. Please use the space below to explain any experience the hospital or any affiliated community partners have had with this type of intervention or target population and how that experience will support the success of the intervention.

Response (Please seek to limit the response to 500 words or less)
Rose Medical Center and our RAE partners currently have processes in place to identify at-risk patients admitted to the emergency department and the medical floors. The RMC case management team makes referrals to COA (Colorado Access) for any medicaid recipient that is in need of community resources upon discharge. COA (the RAE provider) also utilizes Corhio to identify patients that may be at-risk for readmission or in need of post hospitalization follow up care, support and resources. Prior to COVID-19, liaisons from Colorado Access were allowed entry into hospitals for ongoing trainings and collaboration-building events with the case management team. We hope to return to the robust partnership when it is safe to do so.

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)
Discharge planning occurs upon admission for our patients. Case managers proactively screen for patient's social needs and setting prior to the hospitalization, for example housing, transportation, ability to obtain prescriptions, social support, DME, and existing community agencies involved in care. Case management also currently connects patients with financial services to ensure financial aid is initiated prior to discharge. At this time, Rose Medical Center does not currently utilize a standardized screening instrument or transmit this information to the RAE. Standardizing this process will ensure HTP's vision for solidifying a strong partnership and collaboration efforts between Rose Medical Center and our community partners for enhanced patient care and successful transitions into the outpatient setting.

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.