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: Social Needs Screening and Notifications

2. Please use the table below to identify which statewide and selected local quality measures (from the hospital's response to Question 6 in the Hospital Application) the hospital will address through this intervention. As a reminder, each of the statewide and selected local quality measures must be identified for at least one intervention. As such, if this is the only intervention addressing a given Focus Area, all statewide quality measures and all selected local quality measures for that Focus Area must be included in this response. This response should align with the intervention-specific list included in the response to Question 7 in the Hospital Application.

Please note, hospitals are also required to complete the Intervention Proposal below for statewide priorities identified in Question 6 of the HTP Hospital Application.

Please use the unique identification code from the Performance Measures List (which is available on the HTP website) to identify your selected measures. For example, the measure "30 Day All Cause Risk Adjusted Hospital Readmission" should be listed as SW-RAH1.

Response (Please format the response as a numbered list)

1. SW-CP1

3. Please use the space below to describe the intervention and the rationale for its selection. Responses should include:

- A description of the intervention;
- Who will be the target population for the intervention; and
- How the intervention advances the goals of the HTP:
  - ✓ Improve patient outcomes through care redesign and integration of care across settings;
  - ✓ Improve the patient experience in the delivery system by ensuring appropriate care in appropriate settings;
  - ✓ Lower Health First Colorado (Colorado's Medicaid Program) costs through reductions in avoidable hospital utilization and increased effectiveness and efficiency in care delivery;
  - ✓ Accelerate hospitals' organizational, operational, and systems readiness for value-based payment; and
  - ✓ Increase collaboration between hospitals and other providers, particularly Accountable Care Collaborative (ACC) participants, in data sharing and analytics, evidence-based care coordination and care transitions, integrated physical and behavioral care delivery, chronic care management, and community-based population health and disparities reduction efforts.

Response (Please seek to limit the response to 1,000 words or less)

This measure insures that all Medicaid patients discharged to home from an inpatient setting have a documented formal social needs screening during or within 12 months of admission and that positive screens result in appropriate referrals for services and notification to the RAE.

By formally assessing needs, making referrals for services where appropriate and by communicating such referrals back to the RAE, continuity of care will be increased thereby increasing health outcomes and reducing healthcare costs.

Successful implementation of this intervention will require development of a standardized tool for the assessment of needs, identification of and referral to relevant services, documentation of assessment and referral, and the ability to consistently refer this information back to the correctly assigned RAE for each patient. We will work with the RAE to identify community resources and will utilize our health information exchange partner, CORHIO, to send the screening and referral information back to the RAE for out-patient follow up.

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)

The CHNE indicated that Sky Ridge Medical Center's Medicaid patient population is impacted by social barriers impacting follow up care such as inadequate food and housing which will inevitably impact the health of those effected.

Transportation to follow up care was also identified as a need among patients in the CHNE due to lack of robust public transportation as well as the challenges of medically impacted people being able to make use of public transport.

The current economic climate related to the COVID 19 pandemic has introduced job loss and subsequent loss of health insurance as well as increasing financial hardship, both of which can be expected to contribute to increases in the Medicaid population within Douglas County and the Sky Ridge Medical Center catchment area.

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: This measure attempts to address what are commonly known as Social Determinants of Health (SDoH) defined by the World Health Organization (WHO) as "the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life."1 These conditions impact health, well-being and life-expectancy as well as health care costs and utilization.2

Evidence exists to indicate the correlation between housing insecurity3,4, food insecurity4, and violence5 on health care outcomes and utilization of health care systems and is generally well-established in the literature. Impacts of screening and referral for service are not as clear. While some studies exist studying screening and referral for one element of the determinants (e.g domestic violence) or a specific population (diabetic patients, for instance), there are not many studies reflecting outcomes for concurrent screening of multiple domains among a general population.6

For the purposes of this intervention, dimensions to be measured and addressed include (but are not limited to) the five core domains of housing insecurity, food insecurity, transportation problems, utility help needs and interpersonal safety. These domains align with the tool developed by the Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities (AHC) Health-Related Social Needs Tool which was tested by the Center for Medicare & Medicaid Innovation.7,8

The CMS tool draws from validated reporting measures for each of its 10 questions. Regarding housing insecurity, it adapts a question from the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PREPARE) assessment tool9 as well as a question from an article in the Journal of Healthcare for the Poor and Underserved.10 Food insecurity is addressed by questions from the Hunger Vital Sign TM 11 which have been validated and found to be specific. The transportation question was adapted from the PREPARE tool9 and the utility needs question is adapted from the Children's Sentinel Nutritional Assessment Program (C-SNAP) survey.12 The final three questions in the original tool address personal safety and were adapted from the Hurt, Insult, Threaten, and Scream (HITS) instrument which has been validated in multiple settings.13

CITATIONS:

1. "Social Determinants of Health." World Health Organization (WHO). http://www.who.int/social_determinants/en/

2. Healthy People 2020. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

3. Kushel, MB., Vittinghoff, E., Haas, JS. Factors associated with the health care utilization of homeless persons. JAMA 2001;285(2):200-6.

4. Ma, CT., Gee, L., Kushel, MB. Associations between housing instability and food insecurity with health care access in low-income children. Ambulatory Pediatrics 2008;8(1):50-7.

5. Bonomi, AE., Anderson, ML., Rivara, FP., Thompson, RS. Health care utilization and costs associated with physical and nonphysical-only intimate partner violence. Health Services Research 2009;44(3):1052-67.

6. Andermann, A. Screening for social determinants of health in clinical care: moving from the margins to the mainstream. Public Health Rev 39,19 (2018). https://doi.10.1186/s40985-018.0094-7.

7. United States. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2017, September 05). Accountable Health Communities Model. https://innovation.cms.gov/initiatives/ahcm.

8. Billioux, A., MD, DPhil, Verlander, K., MPH, Anthony, S., DrPH & Alley, D., PhD. (2017). Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. National Academy of Medicine Perspectives, 1-9. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-In-Clinical-Settings.pdf.

9. National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PREPARE. http://www.nach.org/research-and-data/prepare/

10. Nuruzzaman, N., Broadwin, M., Kourouma, K., & Olson, D.P. (2015). Making the Social Determinants of Health a Routine Part of Medical Care. Journal of Healthcare for the Poor and Underserved, 26(2), 321-327.

11. Hager, E.R., Quigg, A.M., Black, M.M., Coleman, S.M., Heeren, T., Rose-Jacobs, R., Frank, D.A. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for food Insecurity. Pediatrics, 126(1), 26-32. Doi:10.1542/peds.2009-3146

12. Cook, J.T., Frank, D.A., Casey, P.H., et al, A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. PEDIATRICS 2008;122(4):e867-75.

13. Sherin, K.M., Sinacore, J.M., Li, X.Q., Zitter, R.E., & Shakil, A. (1998). HITS: a Short Domestic Violence Screening Tool for Use in a Family Practice Setting. Family Medicine, 30(7), 508-512.

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: FINI, SNAP, TANF, Denver's Road Home, Colorado Coalition for the Homeless, Homeless shelters and day care, food stamp programs, Access-A-Ride, LIEAP, United Way 211, Child and Adult Protective Services, Safehouse Denver, Gateway Domestic Violence Services and the Colorado Coalition against Domestic Violence. (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)

Statewide initiatives relevant to the 5 identified domains of social determinants of health include Section 8 housing, homeless shelters and day programs, Denver's Road Home, the Colorado Coalition for the Homeless, the Supplemental Nutrition to Assistance Program (SNAP), Temporary Aid to Needy Families (TANF) and food stamp programs, the USDA Food Insecurity Nutrition Incentive Grant (FINI) to incentivize the purchase of fruits and vegetables, the Medicaid medical transportation program and Access-A-Ride, the Low-Income Energy Assistance Program (LIEAP) for help with utilities and the United Way 211-referral line. Addressing domestic violence, there is interface with law enforcement, Child and Adult Protective Services, Safehouse Denver, Gateway Domestic Violence Services and the Colorado Coalition against Domestic Violence.

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)

This would be an entirely new interaction between the hospital and the RAE. We have worked together in the past to coordinate follow up primary care visits for patients discharging from the hospital but there is no precedent for specifically evaluating the social needs of patients and communicating the information back to the RAE.

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)

The current process for evaluating the social needs of hospitalized patients relies primarily on referral to case management from physicians, nursing or other staff or by patients and families themselves. As the focus of case management at Sky Ridge Medical Center up to this point has been discharge planning and utilization review, there is not a process specifically for the evaluation of social needs except insofar as they might impede hospital discharge. When made aware of needs, social work at Sky Ridge endeavors to assist in locating appropriate resources for patients but there has been no communication back to the RAE about these efforts.

9. a. Will the intervention be a joint effort with another organization (e.g., a Regional Accountable Entity, Local Public Health Agency, a mental or community health center, another community organization or any other external organization)?

☒ Yes

☐ No

Partnerships are not required, but, if the hospital will partner, please complete the remainder of this question and provide the required documentation (see subpart c).

b. If yes, please complete the following chart, including listing the partner organization; listing the type of organization; indicating whether the hospital has previously partnered with the organization; and providing a high-level summary of the expected role of the organization in intervention's leadership and implementation.

Partner Organization Name	Type of Organization	Does the hospital have any previous experience partnering with this organization? (Yes or No)	Organization's Role in Intervention Leadership and Implementation (high-level summary)
Colorado Access			

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.