



Hospital Transformation Program

Hospital Application

1. Please use the space below to provide an executive summary clearly articulating how the hospital will advance the goals of the Hospital Transformation Program (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.

The executive summary should:

- Succinctly explain the identified goals and objectives of the hospital to be achieved through participation in the HTP; and
- Provide the hospital’s initial thinking regarding how the HTP efforts generally can be sustainable beyond the term of the program.

Response (Please seek to limit the response to 750 words or less)

EXECUTIVE SUMMARY:

SCL Health’s Hospital Transformation Program (HTP) work is built on five pillars critical to support a health systems’ preparedness to implement value-based care payment models, including: (1) patient and provider engagement; (2) improved technology and data management; (3) patient safety and quality; (4) community engagement; and (5) financial stewardship.

SCL Health is committed to implementing clear and meaningful interventions in each of the focus areas, as identified by the Colorado Department of Health Care Policy and Finance (HCPF). The initiatives outlined in this application represent six specific statewide measures and four local measures. The measure interventions reaffirm that providing cost-effective, high-quality ambulatory, acute, and post-acute care requires a systems-based, multidisciplinary approach. When selecting the interventions, hospital teams focused on serving the most vulnerable patients, for example, patients who are at the greatest risk of being hospitalized.

HTP provides an important opportunity for SCL Health, as well as other hospital systems throughout Colorado, to identify and take action to implement key interventions and strategies that the state has identified as having the greatest opportunity to achieve the program goals outlined in both state statute and state regulation. To that end, SCL Health’s approach in evaluating the selection of measures and interventions took into consideration input gathered from our community partners, attributes of our patient population, and opportunities to leverage system-based efficiencies, strategies and resources. Impacting the cost of care demands that early considerations are given to expand interventions that are working, test new capabilities that speak to social determinant gaps



and to ensure cross agency collaboration. As a result, SCL Health selected the same measures across all hospitals to maximize care improvements and community network build. The additional strength of this program approach supports the demographic and community need overlap represented in our service areas. While the selected measures are initially the same, intervention delivery is unique to address the specific needs of the patient population informed by the CHNE and hospital data.

Medicaid payment reform legislation requires Colorado to move from an out-dated, fee-for-service (FFS) payment model to a more dynamic value-based care model. The success of future risk-based financial arrangements, such as value-based models, requires thoughtful strategic planning and acknowledgment that the timeframes for measurable impact may vary based on the specific intervention. Building considerations for sustainability throughout the implementation phase will be essential to inform ongoing program success. Utilizing multiple evaluation factors such as leadership governance, stakeholder accountability, and patient outcomes, as determinants for fixed or transitional transformations.

CONCLUSION:

Preventing avoidable hospitalization and readmissions (SW-RAH1) requires intake procedures that screen for social determinants of health (SW-CP1) so that care coordination agencies, such as Regional Accountability Entities (RAEs), can be prepared to support both hospital-based and post-acute care by working with patients and case management teams to identify the best methods to ensure that patients are receiving appropriate follow-up care (SW-BH1, CP4 and/or CP6). Last, but not least, hospitalists can increase the likelihood of a successful post-acute visit with primary care physicians and specialists by providing complete, concise discharge summaries in a timely manner (SW-RAH1).

When these interventions occur consistently throughout the system, we expect to see overall reductions in lengths of stay and reductions in avoidable hospital readmissions, which should result in cost-savings for government and commercial payers. Most importantly, at-risk patients will be assured that when they seek treatment at an SCL Health care site, they can be confident they will receive well-coordinated, evidence-based care to support improved health and quality of life.

ABOUT SCL HEALTH:

SCL Health's mission calls us to improve the health of the communities we serve, especially the poor and vulnerable. More than 150 years ago, the founding Sisters of Charities of Leavenworth answered the call as they worked fearlessly and tirelessly to meet the critical health care needs faced by their frontier communities as they founded Saint Joseph Hospital in Denver and St. Mary's Hospital on Colorado's Western Slope. Today, approximately 16,000 SCL Health Associates continue their Ministry in eight hospitals and more than 150 clinics throughout Colorado and Montana. Guided by core values that reflect the integrity, safety, caring spirit, compassion, stewardship, good humor, and excellence in our work, SCL Health continues to answer the call as we identify and pursue new innovative ways to meet the evolving health care needs of our patients.

COMMUNITY HEALTH NEIGHBORHOOD ENGAGEMENT (CHNE):

Having the opportunity to gain deeper perspectives on the needs of the Medicaid population and the various stakeholders who support them has enabled SCL Health to continue to foster on-going collaborations that are committed to finding long-term solutions. The Metro Denver Partnership for



Health has helped to ensure broad outreach. Engagement has been very high among representatives in this group, which was originally created with an intent to develop common intervention strategies for prevalent health issues prioritized in Community Health Implementation Plans, with emphasis on behavioral health.

The inclusive workgroups were established with representative voices from community based organizations, data specialists, technology, and state initiatives. To date, this work is focusing on developing formal relationship consents to ensure that data sharing and HIPAA considerations are included in any established process.

SCL Health's interventions and key measurements for success were informed by our community engagement efforts, organizational goals, quality and patient outcomes and by the prevalent needs of our patients and the communities we serve. We see many direct and indirect benefits in selecting the chosen measurements and the related interventions, which are amplified through a system approach, partnership with the Regional Accountable Entities and social support organizations.



2. Please provide the legal name and Medicaid ID for the hospital for which this Hospital Application is being submitted, contact information for the hospital executive, and a primary and secondary point of contact for this application.

Hospital Name: Good Samaritan Medical Center

Hospital Medicaid ID Number: 7856539

Hospital Address: 200 Exempla Cir., Lafayette, CO 80026

Hospital Executive Name: Jennifer Alderfer

Hospital Executive Title: President

Hospital Executive Address: Same as above

Hospital Executive Phone Number: 303-689-4000

Hospital Executive Email Address: jennifer.alderfer@sclhealth.org

Primary Contact Name: Gaye Woods

Primary Contact Title: System Director Community Benefit

Primary Contact Address: 500 Eldorado Blvd., Bldg. 4, Ste. 4300, Broomfield, CO 80021

Primary Contact Phone Number: 303-813-5027

Primary Contact Email Address: gaye.woods@sclhealth.org

Secondary Contact Name: Cindy Sears

Secondary Contact Title: Sr. Administrator, Front Range Network & Ris Programs

Secondary Contact Address: 500 Eldorado Blvd., Bldg. 4, Ste. 4300, Broomfield, CO 80021

Secondary Contact Phone Number: 303-813-5036

Secondary Contact Email Address: cindy.sears@sclhealth.org



3. a. Please use the space below to describe the planned governance structure for the hospital's HTP engagement and how it will align with the hospital's overall project management capabilities. A description of the governance structure that will be put in place to support the hospital's HTP engagement;

Response (Please seek to limit the response to 250 words or less)

GOVERNANCE STRUCTURE & PROJECT MANAGEMENT SUPPORTS

SCL Health's Hospital Transformation Program (HTP) work brings with it the full backing and support of the health system's leadership, including executive leadership at each of SCL Health's five Colorado hospitals (care sites). The interventions outlined in this proposal are closely aligned with innovative reforms that are part of an ongoing, system-wide initiative to drive transformative change in order to provide patient-centered care, which is rooted in evidence-based practice and guided by data-driven decisions.

SCL Health's HTP work will be led by two teams of leaders. These multidisciplinary teams represent a diverse group of clinicians, subject matter experts, and tacticians who bring with them the experience, knowledge and leadership skills required to implement the ambitious, yet achievable, objectives outlined in the following interventions. The final intervention strategies have also been reviewed and approved by senior leadership teams, which are responsible for ensuring alignment with both the core values that support our mission-driven work and the organizational goals as outlined in Mission Forward 2025, our five-year strategic plan. Executive leaders will ensure the accountability structures support the viability and sustainability of the proposed interventions.

SCL Health views the interventions outlined in the HTP application as a natural extension of the transformative, evidence-based work already underway in each of our care sites and clinics. Transformative work requires transformative leadership; this aspect is reflected in the experienced and committed teams that have been assembled to complete this critical work. The primary teams detailed below are charged with leading SCL Health's HTP work throughout the life of the program. Both teams will receive administrative and planning support from system-level project management professionals who have a proven track record in taking big and bold ideas and creating actionable, efficient work plans that each care site can implement in an efficient manner.

A team of system-level senior executives is ultimately accountable for identifying and approving innovations selected by the HTP Core Team and HTP Site Steering Committees. The following SCL Health leaders will serve on this team: chief financial officer, chief operating officer, chief clinical officer, chief nursing officer, along with vice presidents of payer contracting and strategy, vice president of quality, and the vice president of financial operations. The HTP Core Team will report regularly on progress related to approved HTP measures.

HTP System Core Team: System-level, multi-disciplinary leadership team representing the following departments: Payer Contracting and Strategy, Community Benefit, Quality & Safety, Performance Improvement, Finance, and Information Technology & Digital Support (ITDS).

Responsibilities of the HTP System Core Team: 1) ensuring frequent communication and engagement with relevant stakeholders throughout the organization; 2) consulting with SCL Health departments, community partners, philanthropy teams, and other stakeholders, as appropriate, to complete interventions identified by this application; 3) coordinating intervention efforts with a diverse group of internal stakeholders, such as Hospital Medicine Leadership Council, Acute and



Ambulatory Quality Councils, Emergency Medicine Leadership Council, Physician Executive Leadership Council, and the Service Excellence Committee; and 4) working closely with Enterprise Business Analytics and ITDS to design an HTP dashboard that can be rolled out over the next year (coinciding with the “HTP implementation phase,”), to track and report performance progress for each of the identified measures.

HTP Site Steering Committees: Multi-disciplinary leadership team established at each SCL Health hospital (called care sites) charged with the responsibility for coordinating and managing care-site level implementation of HTP interventions and initiatives. Leaders who are appointed to serve on the Committee represent more than seven departments, including Executive Leadership, Quality and Safety, Finance, Performance Improvement, Case Management, and Community Benefit.

Responsibilities of the HTP Site Steering Committees: 1) reviewing HTP criteria, available data and other relevant information; 2) identifying opportunities through HTP that align their care site with SCL Health System initiatives; 3) leading implementation efforts at each care site; and 4) collecting and reporting qualitative and quantitative data required to demonstrate performance and progress for each statewide and local HTP measure identified by this application; 5) Community Benefit leads participate on the Site Steering Committees and function as a key point of contact and outreach for community stakeholder groups to ensure ongoing communication.

- b. How the planned structure has been adapted to the needs and unique experiences of the hospital and how it will ensure successful oversight of the hospital’s HTP engagement;

Response (Please seek to limit the response to 250 words or less)

SCL Health provides support for HTP work at both the System level and the care site level with multidisciplinary teams in both settings. The work is woven into all areas of the organization under each applicable service line for each measure, overseen by the System and care site HTP teams. Having the interdisciplinary teams involved in the oversight is a sustainability strategy and helps to anchor the integration. Additionally, SCL Health strategic goals around clinical and operational transformation intersect with many of the identified priorities of the HTP program. These program intersections place a high priority on performance and consistent reporting.

- c. Specifically, how the structure will ensure management and transparency and engage members of impacted populations and community partners;

Response (Please seek to limit the response to 250 words or less)

As a result of having oversight from a system-level senior executive team, a system level HTP Core Team, and HTP Site Steering Committees there is engagement at all levels to capture a multidisciplinary approach to ensure diverse and well rounded input into the work. The HTP Site Steering Committees not only bring their service line expertise to the conversations but also the experience of the patients at their care sites. Combining this information with CHNE feedback will lead to work that will meet the needs of the patients and communities we serve. Communicating with the community through the required CHNE work will ensure transparency to patients and partners. Examples of the bi-directional engagement with community members includes the annual public meeting, leveraging existing stakeholder meetings to include agenda time for HTP feedback, and regular performance meetings with social support organizations. In addition to the CHNE, SCL Health care sites will invite feedback on HTP and other healthcare topics as a component of the Community Health Needs Assessment process which includes surveys, individual interviews and focus groups during the 2021 assessment period.



- d. The overall project management structure of the hospital, including how it is organized into operational, clinical, financial, and other functions, and how it will be leveraged to support the hospital's efforts under the HTP and the governance of those efforts;

Response (Please seek to limit the response to 250 words or less)

A team of system-level senior executives is ultimately accountable for identifying and approving innovations selected by the HTP Core Team and HTP Site Steering Committees. The following SCL Health leaders will serve on this team: chief financial officer, chief operating officer, chief clinical officer, chief nursing officer, along with vice presidents of payer contracting and strategy, vice president of quality, and the vice president of financial operations. The HTP Core Team will report regularly on progress related to approved HTP measures.

The HTP Core Team at System-level includes a multidisciplinary leadership team representing the following departments: Payer Contracting and Strategy, Community Benefit, Quality & Safety, Performance Improvement, Finance, and Information Technology & Digital Support (ITDS).

The Good Samaritan Medical Center HTP Site Steering Committee also consists of multidisciplinary leadership teams established at each SCL Health hospital (called care sites) charged with the responsibility for coordinating and managing care-site level implementation of HTP interventions and initiatives. Leaders who are appointed to serve on the Committee represent more than seven departments, including Executive Leadership, Quality and Safety, Finance, Performance Improvement, Case Management, and Community Benefit.

The HTP Core Team is supported by a Project Manager from the Enterprise Program Management Office. The Project Manager is responsible for an internal environmental scan to ensure all appropriate stakeholders are engaged at System and Care Site level. The Project Manager implements structure to the HTP work to facilitate and ensure internal collaboration in cross functional teams across the organization, communication plans, workflow mapping and task tracking, and more.

- e. How the hospital's project management structure is aligned with the hospital leadership structure; and

Response (Please seek to limit the response to 250 words or less)

SCL Health's Hospital Transformation Program (HTP) work brings with it the full backing and support of the health system's leadership, including executive leadership at each of SCL Health's five Colorado hospitals (care sites). A team of system-level senior executives is ultimately accountable for identifying and approving innovations selected by the HTP Core Team and HTP Site Steering Committees. Project and Program Management are members of the Site and System Core Teams as well and help to guide and organize the work.

The interventions outlined in this proposal are closely aligned with innovative reforms that are part of an ongoing, system-wide initiative to drive transformative change in order to provide patient-centered care, which is rooted in evidence-based practice and guided by data-driven decisions.

- f. The current state of centralized reporting capabilities for the hospital.

Response (Please seek to limit the response to 250 words or less)



SCL Health is prepared with a centralized reporting plan to be executed over the HTP Implementation years. SCL Health has EHR and robust data analytical capabilities and will be able to meet the requirements of the HTP Program. Currently we have standard canned reports from our Epic application and the flexibility to pull custom reports from our Caboodle data warehouse. SCL Health will grow the reporting capabilities during HTP Implementation years.

4. Please use the space below to describe the hospital's plan for continuing Community and Health Neighborhood Engagement throughout the hospital's HTP participation. A detailed plan is not required. Instead, hospitals can outline a high-level approach to CHNE going forward, including, for example, the stakeholders to be engaged and the types and frequency of activities to be used. Hospitals should consult the Continued Community and Health Neighborhood Engagement document, which can be found on the [HTP webpage](#), to ensure their planned activities fulfill program requirements.

Response (Please seek to limit the response to 500 words or less)

COMMUNITY HEALTH NEIGHBORHOOD ENGAGEMENT (CHNE)

Each SCL Health hospital in Colorado has completed the required Community Health Neighborhood Engagement process, including gathering feedback and input from a variety of community stakeholders.

Ongoing engagement efforts will follow the principles of continued engagement outlined in the HTP guidelines including:

- Engaging a broad section of community partners - clinical, health advocates and support agencies.
- Providing necessary accommodations for cultural, linguistic, and physically appropriate methods to increase participation.
- Utilizing multiple communication formats to announce public meetings, progress reports, and feedback opportunities. Formats include direct mail, handbills, advertisements and social media.

CHNE activities will continue throughout the hospital transformation program and will address three categories - HTP core stakeholders (e.g. RAE's, Public Health, Mental Health and SDOH agencies), public meetings (e.g. HTP annual public meeting, Community Benefit Accountability annual meeting), and community advisory meetings (e.g. Program Improvement Advisory Committees and Health Alliances).The annual learning symposium will also provide an opportunity for data review and shared performance of all HTP participants.

Several multidisciplinary work groups, such as the Metro Denver Partnership for Health (MDPH) collaborative have been active through bi-monthly meetings in an effort to establish common improvement practices around care coordination. The MDPH meetings began two years prior to HTP, but have become a critical point of engagement to ensure bi-directional stakeholder communication and alignment. Local RAE's and hospital systems have also established regular meetings to ensure clarity and accountability for health change strategies.

Additional subject matter experts will be invited, as needed, when developing interventions for particular measures, such as individuals from the Colorado Health Institute, Colorado Department of Public Health & Environment, and Colorado Health Foundation. Organizations representing social



support areas will also be included in order to build a more robust social support resource database (for example: older adult services, legal aid, housing, food agencies, and more). Input from these partnerships will be foundational to the screening and referral infrastructure needed to address areas related to the Social Determinants of Health.

Finally, while several of the stakeholder partnerships mentioned above are essential to multiple SCL Health care sites due to overlapping service areas, the following list represents unique relationships that are especially important to the work at Good Samaritan Medical Center, such as Clinica Family Services, Salud, CO Community Health Alliance, CCHA, Boulder County Public Health, Boulder County Area Agency on Aging, Sister Carmen Community Center, and the Metro Denver Partnership for Health collaborative. In addition, Good Samaritan Medical Center hopes to increase collaboration with EDs and community Fire Depts to develop and implement a CARES program. Frequency of interactions with stakeholders will vary by type, but on average will result in 4 to 6 contacts per year. Impacts resulting from COVID-19 will be considered when sharing information and requesting responses from the general public. We want to make every effort to show concern and flexibility to the needs of our community members.

5. As part of continuing Community Health Neighborhood Engagement (CHNE), hospitals must share a draft of their application with stakeholders to allow them the opportunity to provide feedback for hospitals' consideration. This Public Input process must last at least 10 business days, with an additional 5 business days allotted to hospital review and response to any Public Input received. Hospitals must submit applications by **April 30, 2021**, but hospitals may resubmit revised applications with revisions based solely on feedback from the Public Input process by **June 30, 2021**. The Department of Health Care Policy & Financing will also make submitted applications public once applications are complete and approved by the review board. Please refer to the Ongoing CHNE Requirements document on the Hospital Transformation Program website for a list of key stakeholder categories. At a minimum, the stakeholders should include those who engaged in or were invited to engage in the CHNE process.

Has the Public Input process been completed and does this draft incorporate any potential revisions based on that public feedback:

Yes

No

Please enter the dates of your proposed or completed Public Input timeline. If you have not yet completed your Public Input process by the initial submission deadline of April 30, 2021, please fill in proposed dates. You will need to fill in the actual dates when you resubmit your application at the conclusion of the Public Input process by June 30, 2021. Please use **mm/dd/yyyy** format.

Proposed Public Input Period : 02/08/2021 to 02/28/2021

Proposed Hospital Review of Public Input Period: 03/01/2021 to 03/31/2021

Actual Public Input Period : 02/08/2021 to 03/26/2021

Actual Hospital Review of Public Input Period: 03/01/2021 to 03/31/2021



If you answered no to the above question and your submission is subject to change based on an ongoing Public Input process, please note that you must turn in your revised application by April 30, 2021. After incorporating your Public Input process changes, applicants are required to submit both a clean and a red-lined version of the Hospital Application to aid HTP review staff in identifying the Public Input based changes compared to your initial submission.

Please use the spaces below to provide information about the hospital's process for gathering and considering feedback on the hospital's application.

Please list which stakeholders received a draft of your application and indicate which submitted feedback.

Response (Please seek to limit the response to 250 words or less)

Colorado Access, Colorado Community Health Alliance, City and County of Denver, Jefferson County Public Health, Tri-County Health Department, Denver Public Health, Jefferson Center for Mental Health, AllHealth Network, Signal Behavioral Health, Center for Health Progress, Hunger Free Colorado, Center for African American Health, Broomfield FISH, Mile High Health Alliance, Aurora Health Alliance, Adams County Health Alliance, Douglas County Health Alliance, Boulder County Health Improvement Collaborative, Community Health Centers, CORHIO, InnovAge, Colorado Coalition for the Homeless, Colorado Cross-Disability Coalition, Colorado Justice Reform Coalition, Colorado Children's Campaign, Every Child Pediatrics, Denver Regional Council of Governments, Mile High Foothills RETAC, Health Colorado Inc, and Northeast Health Partners.

Please explain how the draft application was shared and how feedback was solicited.

Response (Please seek to limit the response to 250 words or less)

Colorado based healthcare providers agreed to share the HTP applications uniformly in an effort to allow community stakeholders to review and compare applications. Our hope was to minimize the distress within the feedback process for organizations like public health that would be receiving requests from multiple hospitals. Our simultaneous release of applications and the feedback survey allowed organizations the opportunity to review the measure specific components of the application by hospital.

Applications were disseminated via email notification to the targeted HTP list including public health, RAE's, health alliances, mental health centers, Federally Qualified Health Centers, consumer advocates, and other identified community partners at the beginning of February 2021.

Community members had approximately thirty days to provide feedback via the survey instrument which accompanied the application or through direct contact to the hospitals' identified representative. Each hospital may also share the application with their individual local partners. All SCL Health care site HTP applications were available on each hospital website and an email announcement to the database of community partners alerted members on how to access the link. As an additional effort to invite community stakeholder feedback, HTP participating health systems planned and facilitated a joint virtual meeting and discussion of the applications with a focus on further dialogue about the dominant themes originating from the survey results - reducing readmissions, improved discharge planning, and social needs screening and referral.



With a bulleted list, please list the shared stakeholder feedback and explain if any changes were made to the application based on the feedback. If no changes were made, please explain why. If the same or similar feedback was shared by more than one stakeholder, please list it only once.

Response (Please seek to limit the response to 500 words or less)

The feedback heard during the engagement with community partners consists of the following bullet points:

-Addressing readmissions is critical in managing cost and care efficiencies while reducing gaps in care for patients. The connection of patients to their post-acute follow-up care and eliminating barriers to that care is also called for. A concern was expressed that barriers to ambulatory mental and behavioral health services contribute greatly to patients readmitting and that increasing capacity for patient services external to the healthcare facility, such as a hospital, will have a huge reduction in over utilization of emergency departments. How can hospitals do more to partner with organizations that are serving at the grassroots level to address prevention. Lastly, closed looped referrals are highly desirable.

-Addressing social determinants of health is extremely important for the Medicaid population and connecting to a centralized database for care management might help reduce over utilization and readmissions, as well as increase coordinated care across the healthcare systems. Monitoring and use of data to help direct work on specific categories of social determinants is available and useful. An example would be that of the work that Adams County is doing to collect data on supportive housing to guide interventions for patients with housing insecurities.

-Access to mental and behavioral health services along with transitions of care and post-acute access are important in improving patient outcomes and ensuring that patients get connected with post-acute mental and behavioral health services.

-Maternal health and maternal mental health is a priority in the community and reducing the associated level of stigma. Additionally, there is hesitancy for perinatal patients to engage in mental health screenings due to fear of child welfare involvement on positive screens. Community is interested in ways to break down the stigma through HTP work.

-We heard from the RAEs that hospitals should consider them a partner and work in a collaborative way to plan for patient referrals and RAE notification. It was also mentioned that we should partner to target certain high risk sub-populations within the Medicaid beneficiary population that might most benefit from a hospital site to RAE notification.

SCL Health values and appreciates all community engagement and the time that partners spent reviewing the applications and the time taken to give feedback. The feedback gained is consistent with feedback from previous CHNE engagement efforts and other hospital and community partnerships. The feedback has been included in the application and was a major factor in determining the measure selections. All of the SCL Health selected measures and interventions such as with maternal mental health, screening for transitions of care for adults with disabilities, telehealth, and patients with ischemic stroke discharged with statin meds aligned with feedback areas. The measure interventions take aim at improving mental health screenings for perinatal patients, improving barriers to post-acute care for the vulnerable populations living with disabilities, increased access to services through virtual care as recently seen during the COVID-19 emergency,



and lastly, intervention done to reduce the the potential for disability in patients with ischemic stroke. Finally, all the mandated measures aim at working consistently with community feedback and needs that can impact SDOH.

Please consult the accompanying Intervention Proposal before completing the remainder of this application.

6. Please use the space below to identify which statewide and local quality measure(s) from the [HTP Measure List on the Colorado Hospital Transformation Program website](#) the hospital will address for each Focus Area.

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.

As applicable, please identify the Statewide Priority your hospital is pursuing as a part of the HTP Hospital Application:

- SP-PH1 – Conversion of Freestanding EDs
- SO-PH2 – Creation of Dual Track ED

Please note that hospitals are required to complete the accompanying Intervention Proposal for the statewide priorities identified above.

The selections should align with the hospital's improvement priorities and community needs. As a reminder, hospitals must adhere to the following requirements when selecting quality measures:

- 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.

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. SW-CP1
3. SW-BH1
4. SW-BH3
5. SW-COE1
6. SW-PH1
7. RAH4
8. CP6
9. CP4
10. COE2

7. Please use the space below to identify all of the hospital’s proposed interventions. Following each listed proposed intervention, please identify which of the measures from the response to Question 6 will be addressed by that intervention. Please list the unique identification code listed in response to Question 6 to identify the applicable measures and please format your response in accordance with the following example:

1. Intervention Name
 - a. Measures: SW-RAH1, RAH2

Response (Please format the response as a numbered list)

1. Readmissions Reduction Collaborative
 - a. SW-RAH1
2. Social Determinants of Health (SDOH) Screening and RAE Notification
 - a. SW-CP1
3. Collaborative Discharge Planning and RAE Notification
 - a. SW-BH1



4. ALTO and Opioid Safety
 - a. SW-BH3
5. Hospital Index-Care Redesign
 - a. SW-COE1
6. Patient Flow - Length of Stay (LOS)
 - a. SW-PH1
7. Patients with Ischemic Stroke Discharged with Statin Medications
 - a. RAH4
8. Maternal Mental Health Collaborative
 - a. CP6
9. Screening for transitions of care in Adults with Disabilities
 - a. CP4
10. Telehealth Implementation and Expansion
 - a. COE2

Hospital Transformation Program

Intervention Proposal - Good Samaritan Medical Center

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: Readmissions Reduction Collaborative
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

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)

PROPOSED INTERVENTIONS & DESCRIPTION

Readmissions Reduction Team & Readmissions Reduction Action Plan

**Focus Area - Reducing Avoidable Hospitalization Utilization
SW-RAH1: 30-Day All-Cause Risk Adjusted Hospital Readmission**

Focus Area - Clinical and Operational Efficiencies

The Readmissions Reduction Team will lead the development of a Readmissions Reduction Action Plan in order to meet the following objectives:

- 1) Support improved transitions of care and length of stay (LOS) interventions, ensuring that patients receive the “right care” at the “right time” in the “right place” by providing timely and uniform discharge summaries to caregivers, including primary care physicians, specialists, and long-term care facilities;
- 2) Determine the feasibility and cost-effectiveness of leveraging existing technologies (EHR) and tools (Project BOOST 8P Screening Tool) to upgrade EHR in order to provide hospital care teams with a predictive tool that, upon completion of the admission and registration process, may be able to identify patients who are “at-risk” of post-discharge complications and increased readmissions.
- 3) Determine which elements of a coordinated care plan may show the greatest likelihood of improving patient outcomes, including reducing 30-day readmission rates.*



*NOTE: Recent research indicates that by giving pharmacists an express role in medication management and providing pharmacists with access to EHRs may play a role in reducing readmission rates.

4) Identify specific policies and procedures that leverage the primary care provider's role in improving post-discharge follow-up, potentially modeled after research that shows promising results of health plans' "bundled intervention strategies."

5) Develop a plan to redesign and to improve the process for discharge summaries in order to support follow-up care by a) standardizing format and transmission procedures; b) incorporating details related to in-hospital medication management; and c) redesigning format to focus information on most relevant, actionable information related to the patient's hospital stay.

6) Implement strategies that will identify innovative case management tactics and/or communications strategies that may show promise in contributing to reduced 30-day readmission rates*

* NOTE: Should acknowledge that research to-date fails to establish a clear connection between post-discharge phone calls and reduced readmission rates, except for one study that showed that increased frequency in outreach via IVR, as opposed to calls placed by a human, appeared to decrease readmission rates by an impressive 44%.

7) Ensure that a patient's coordinated care plan, including post-discharge plan, identifies: a) existing (or likely) barriers to follow-up care, including transportation to appointments, and availability of appointment with PCP; and b) areas where the patient is vulnerable to additional stress created by financial burdens, such as out-of-network reimbursement fees, lack of coverage for post-discharge services, or increased cost-sharing obligations.*

*NOTE: More applicable in situations where coverage is a high-deductible health plan.

8) Support development of innovative strategies that improve communication between primary care physicians and hospitalists in advance of and during hospital stay, as well as including any pharmacists and nurse care managers who are familiar with the patient's situation. For instance, the team may further consider automated notifications to PCPs upon hospitalization, which showed promise in reducing readmission rates, while also identifying potential challenges in EHR compatibility, and challenges in operationalizing interventions; and

9) Ensure that the coordinated care plan, including the post-discharge care plan, is consistent with the patient's own care goals (social, emotional, financial) and, if appropriate and/or feasible, provides for patient input, including collecting data in order to identify the extent to which the plan substantially reduces the potential for, as well as the occurrences of, 30-day hospital readmissions.

TARGET POPULATION

The target population under the Readmission measure intention would be any Medicaid patient that has an identified risk of readmission. The Readmission Reduction Team's aim is to address readmissions for all populations, including Medicaid, and any sub groups where trends are identified. Some of the trends identified in data have been Medicaid patients ages 16-44, patients covered under Medicaid expansion criteria, the African American population, and patients that are homeless. Good Samaritan Medical Center's community partners identified individuals with significant health needs, co-occurring conditions and/or high utilizers as a population of focus. These individuals may have undiagnosed or untreated behavioral health concerns that are driving their care utilization and poor health and are likely to have experienced some form of trauma or adverse experiences. High



emergency department utilization, or “mis-utilization” such as using emergency departments for primary care services, may be influenced not by emergent health conditions but by limited access to primary and/or specialty care in outpatient settings. This limited access may be due to providers not accepting Medicaid, individuals disconnected with or unaccustomed to accessing care in a primary care medical home, and/or providers not being available during evenings and weekends. Lastly, the emergency department may be a safe place for individuals experiencing homelessness or other threatening home environments.

CONNECTION BETWEEN INTERVENTION & HTP GOALS

Readmissions-related events may also increase the severity of complications and discomfort associated with post-discharge recovery, increasing the risk that patients seek narcotic-based pain relief. These delays may have a ripple effect as caregivers scramble to adjust their schedules and availability to account for the subsequent readmission.

The Agency for Healthcare Research and Quality (AHRQ) issued a report in March 2020, evaluating the effectiveness of myriad intervention strategies and concluded that, while no single intervention could be proven to, on its own, reduce readmissions rates, it is likely that a coordinated, multifaceted strategy to implement early identification of patients at-risk for readmission combined with coordinated care plans could show the greatest amount of promise. The report called out the effectiveness of coordinated care plans that included hospital-based treatments and interventions, followed by intentional and frequent outreach to patients in the post-discharge period.

To date, managed care organizations’ efforts to “bundle interventions” appear to be the most successful post-discharge care strategy. Peer-reviewed research also indicates that the success of clinic-based interventions increases when the patient’s clinic is part of an integrated care network or health care system. Work completed as part of this intervention may help our clinical teams identify whether or not Colorado health systems can replicate this same benefit.

As Colorado’s Medical Assistance Programs (Medicaid, et al) enter the next phase of the Accountable Care Collaborative, including full implementation of value-based payments and capitation behavioral health payments to the RAEs, it will be critical to have a better understanding of how coordinated care plans and post-discharge plans can be best incorporated into existing structures. The success of the Patient-Centered Medical Home relies on regulators, clinicians, and policymakers having a clear picture of how proposed interventions do or do not materially impact both the quality of and the cost of care.

NOTES & DEFINITIONS

Readmissions Reduction Team: A multidisciplinary team, established by SCL Health System Leadership to provide system-level continuity, support, and accountability for hospital-based care teams that are responsible for establishing and implementing a patient’s coordinated care plan.

Discharge Summaries: Reports completed by hospitalists that provide both a synopsis of the patient’s hospital-based treatment and care, as well specific details relevant to the patient’s diagnosis. The information included in discharge summaries is intended to help a patient’s primary care physicians, specialists and other post-acute health care providers.



Coordinated Care Plan: Individualized care plan, available as part of the patient’s Electronic Health Record, that expressly includes the following information:

- appropriate discharge summaries,
- discharge plans and transitions of care plans; and
- post-discharge plan for follow-up by appropriate health care providers, including primary care physicians, specialists, and other providers, such as home health care agencies, therapies, and more.

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)

A NOTE TO READERS REGARDING CHNA vs. CHNE:

Two different acronyms - CHNA and CHNE - are used throughout the application to refer to similar, yet substantively different, processes. CHNE refers to community engagement and outreach that was solicited specifically as it relates to HTP partnerships. CHNA refers to the larger health needs assessment that captures health needs, regardless of the connection to HTP interventions.

Each Community Health Needs Assessment identifies patients in our communities who are at-risk for chronic illness and disease and/or susceptible to other factors that impact an individual’s overall health and ability to thrive. The patients who are best positioned to benefit from improved coordination of care are consistently the same patients identified by our CHNAs as being underserved or at-risk of having unmet health care needs. SCL Health leveraged the CHNE process to begin outreach to community members and set the framework for more structured partnerships as part of HTP. Through the CHNA and CHNE processes in the Lutheran Medical Center community we have learned that access to behavioral health appointments, food insecurities, and housing insecurities are top reasons for readmissions for this population.

Good Samaritan Medical Center will define its community based on the CHNA scope which includes eighteen cities crossing 6 counties - Broomfield, Boulder, Jefferson, Adams, Gilpin and Weld. Cities that dominate as primary service reach areas include Lafayette, Broomfield, Northglenn, Westminster, Thornton, Erie, Superior and Arvada. Additionally, aligning service areas between the CHNE and the CHNA definition further supports the consistency of community engagement, partnerships and intervention selection to serve HTP priority areas and the hospital’s CHIP.

Recent studies suggest that an overwhelming majority of adult “newly eligible” Medicaid members, as they are known under Medicaid expansion, have at least one, if not more than one, chronic health condition. This group of adults, most of which are not likely to qualify for supplemental disability benefits or be old enough to qualify for Medicare, are frequently working full-time in stressful,



physically demanding jobs. They are likely principal sources of income for their households. The demands on their time post-discharge likely leave little time for them to manage their own care, given that they are often caregivers for children and other family members, such as elderly parents.

Well-being for individuals and the communities in which they live are inextricably linked. Gaps in meeting essential needs (which are also reflected in Social Determinants of Health, as covered in SW-CP1) directly impact the health of individuals, which in turn directly impacts the overall health of a community. Communities disproportionately impacted by the disparate health outcomes related to COVID-19 infections, for example, face significant challenges in establishing a “new normal.” Communities hit hard by economic downturns in service industries and the hospitality industry face even greater financial pressure, as they juggle housing expenses, increased food prices, and the expenses associated with lost before and after school child care programs. Last, but not least, clinicians still do not have a clear picture of how the long-lasting health impacts on COVID-19 survivors will have an affect on the system as a whole, especially if future waves coincide with outbreaks of other infectious diseases, such as the seasonal flu.

Reduced economic activity inevitably impacts tax revenues, as well as reduced charitable contributions. Local governments and community partners become more and more revenue constrained, the demands on health systems to provide wrap-around support services will only continue to grow. These critical safety net services, such as food pantries, affordable housing programs, transportation programs designed to connect at-risk patients with community services, have been historically provided by local governments and agencies.

Mission Integration and Community Benefit teams at each SCL Health care site have used data gathered in their CHNA’s to prioritize investments in food security programs, programs that provide prescription medications directly to patients upon discharge from the hospital, and mobile telemedicine units in areas where a lack of broadband internet access serves as a barrier to patients accessing online resources designed to streamline their care.

It’s important to note that while HTP goals delineate “readmission rates” the issue isn’t one that is specifically called out in our most recent CHNA’s. That said, many issues related to readmissions are often raised by community members and community providers. These issues include concerns about health disparities based on race or income, and challenges in managing the long-term impacts of chronic diseases. The lack of coordinated care strategies among behavioral health providers, hospitals, substance use disorder treatment programs, and primary care providers surfaced at several community engagement events that occurred in late-2019 and early-2020.

Coordinated care issues usually surfaced as part of a broader conversation about increasing access to preventative care and behavioral health services as a way to reduce utilization rates in emergency departments. As SCL Health plans for the 2021 CHNA process, we can engage patients and caregivers in a thoughtful discussion about how to improve post-discharge care coordination to further advance “patient-centered care.” By implementing the interventions discussed above we expect to impact the goals of improving appropriate care in appropriate settings, reducing avoidable hospital utilization and readmissions, accelerating readiness for value-based payment, and increasing collaboration between the care site and other providers.

Disruptions caused by COVID-19 will undoubtedly change the nature of coverage provided by employer-sponsored insurance (ESI), although we may not have a clear picture of these impacts until 2021 and beyond. The high growth employer-sponsored high-deductible health plans, as well as



frequent changes that occur in a health plan's network of providers, will add an additional layer of complexity to coordinated care plans and post-discharge care plans as case managers and providers take into account a patient's financial standing and their ability to cover cost-sharing obligations for follow-up care.

NOTES & DEFINITIONS:

Community Health Needs Assessment (CHNA): Official name of a federal requirement (per the Affordable Care Act) that tax-exempt hospitals, at least every three years, engage in a formal process in order to determine the current health needs of the communities they serve, as well as actively engage with the community to identify self-identified needs and gaps in care. The process is officially reported out in the form of a report called the CHNA.

Community Health Needs Engagement (CHNE): Process, as well as progress reports, that are required by HTP regulations and guidance. CHNE refers to a pre-program process that occurred in HTP investigatory, or pre-program, phases. The work and health needs overlapped considerably with community engagement work centered around the CHNAs and community investments (also called community benefits) made by tax-exempt hospitals.

The interventions were arrived at through a combination of data analysis, alignment with CHNE/CHNA findings and HTP priorities. The Hospital initially inventoried current initiatives and programs in comparison to the HTP priority areas. To narrow the field further, the hospital looked for common themes that overlapped with the CHNA and CHNE findings and compared results to internal utilization and Prometheus data for depth of financial impact. Finally, the hospital evaluated the list of interventions for common opportunities with System initiatives and other government programs. This final step is critical to reducing cost and ensuring interventions can be applied across all populations, therefore creating operational efficiencies while maintaining the same standard of care. Some of the System and government initiatives with HTP application are SCL Health's strategic imperative for clinical and operational transformation and SCL Health's planned participation in the CMS Bundled Payments for Care Improvement, Advanced (BPCI-A) model. Care redesign, creating operational efficiencies, and cost reduction are central elements of both initiatives and the interventions they generate will be applied across all payers. Many of the DRGs included in the BPCI-A model are conditions identified as cost or PAC opportunities on the Prometheus Hospital Index reports. SCL Health's care redesign efforts can be standardized and applied to both state and federal initiatives. However, the one variance is that BPCI-A provides ongoing claims detail of not only the hospital stay, but all claims incurred post-discharge for a 90-day period which provides the hospital with insights not otherwise available. Through this claims data, the hospital can tailor interventions for specific cost-outliers such as reducing readmits or SNF length of stay by providing Navigators who follow patients post-discharge for extended periods.

Community stakeholders involved in this work include but are not limited to: Clinica (medical home, referrals), Mental Health Partners (mental health services, referrals), Community Reach Center (mental health services, referrals), Tru Community (PACE, adult community center, transportation), SCL primary care physicians (transition of care coordinators), Choice House (sober living and intensive out-patient, 90-day treatment), CCHA (RAE), SUAG (Boulder County Public Health, substance use resources, strategies, etc.), HFC (youth/young adult substance use prevention), and Colorado ALTO Project (opioid safety pilot through Colorado Hospital Association). Other partners will be engaged as necessary.



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)

SUMMARY OF RESEARCH & EVIDENCE-BASED PRACTICES

Decades of research into the root causes driving readmissions during the first 30 days post-discharge have failed to isolate either a primary cause for readmissions or the singular intervention strategy that has proven most effective, even among subpopulations of patients. That said, several evidence-based strategies confirm the effectiveness of interventions that adopt a multifaceted approach, combining multiple hospital-based interventions with a variety of follow-up tactics designed to meet a patient's unique circumstances. In other words, readmissions reductions require multiple supports being implemented, sometimes repeated frequently, by multiple providers.

The Society for Hospital Medicine's BOOST Program (Hansen et al, 2013), as well as two other evidence-based programs recognized by the Agency for Healthcare Research and Quality (AHRQ), reference many of the interventions identified in this proposal, however, not all of the proposed interventions were included in this particular body of research. The literature covering the effectiveness of these early identification programs are an amalgamation of Randomized Control Trial, retrospective observational studies, and prospective cohorts.

Federal agencies recently released research that shows that standardization of discharge summaries sent by hospitalists to primary care physicians can help facilitate more successful post-discharge care (Snow, et al, 2020). This latest overview confirms the results published over the last five years, in which the discharge summary only makes it to the primary care provider in 12 to 34 percent of follow up appointments by the time that initial appointment occurs and may not be complete enough for appropriate follow up (Alper, et al, 2020). Other researchers have found that delays in the completion of the discharge summary lead to increased risk of readmission (Hoyer et al. 2016).

Post-discharge communication can positively impact the follow-up by patients, however, as communication technology rapidly evolves, research is regularly being published to shed light on the effectiveness of emerging, as well as more traditional, communication technologies. In one retrospective cohort study, over 30,000 patient encounters were evaluated post-discharge to determine the impact of a telephone follow up call within 14 days of the initial appointment. Researchers concluded that individuals who were successfully contacted had a 23% decrease in chance of readmission within 30 days (Harrison et al, 2014). Specifically in the Medicaid population,



a more broadly defined study on post-discharge engagement identified a 33% decrease in 30 day hospital readmissions after the implementation of interventions (Gao et al, 2018).

Of note, recent evidence suggests that it's not only nurses' post-discharge calls that could have an impact on readmissions rates, but also the frequency with which those calls are placed.

Peer-reviewed studies confirm that early identification of patients who are at-risk of complications that result in readmissions can be part of a comprehensive program to reduce readmissions rates.

Clinicians are already utilizing screening tools, such as Project BOOST's assessment, to flag patients who need additional support following through on post-discharge care plans. Additionally, automated predictive tools can be constructed as a part of EHR systems. Evidence suggests that automated EHR systems may offer a higher predictive value than a number of other assessment based tools, thereby improving the application of resources ("Cognitive Computing Model...", 2016).

As part of the Readmissions Reduction Plan developed by the system-level team, SCL Health is able to work collaboratively with designers of EPIC, which serves as the platform for our patients' electronic medical records, to improve how our system meets our patients' needs. Working closely with the platform engineers, any redesign and integration effort can allow a health care provider to incorporate information gathered as part of a BOOST assessment into the EHR's predictive tool. It will enable the tailoring of the assessment of those patients for specific interventions utilizing the Project BOOST tools (Hansen et al, 2013). Project BOOST incorporates a further assessment to identify specific risks. Each identified risk should trigger an intervention or group of interventions to prevent readmissions. The RCT used to evaluate the effectiveness of screener the Project BOOST documented significant reductions in readmissions rates.

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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)



The work led by the Readmissions Reduction Team (RRT) will ensure that interventions, and resources invested in support of the initiative, will align with ongoing initiatives, such as the Medicaid payment reforms that are central to the work of the Department’s Accountable Care Collaborative. Future initiatives, such as those associated with the Primary Care Collaborative and managed by representatives of the Colorado Division of Leadership, will be closely monitored and flagged for review so that the RRT can make adjustments to this program to ensure continued alignment with other payment reform programs.

Since this work spans the next several years, it will be critical that intervention policies and procedures are also aligned with initiatives that will be finalized in mid-2021, such as the Behavioral Health Task Force’s blueprint for improving Colorado’s mental health.

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)

In early 2020, prior to the onset of COVID-19, SCL Health convened a “Readmission Collaborative” to begin 1) evaluating internal data related to patient readmissions over the last several years; and 2) identify opportunities to prevent readmissions. While SCL Health teams have explored isolated sets of readmissions data, the system has not yet embarked on a wide-scale effort as proposed in this application.

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)

SCL Health leadership has organized the system-wide Readmissions Reduction Team, however, we anticipate the Team’s workload will continue through the life of HTP. The first round of work by the Readmission Reduction Team will focus on identifying current practices as they relate to evidence-based practices and other shared “best practices.” After the initial investigation phases, the Team will build out a longer term initiative focused on reducing readmissions of Medicaid members. As the RRT works collaboratively with HTP Care Site Teams to develop and build-out a comprehensive intervention program, updates will be included as part of the HTP reports provided to HCPF. Should the Hospital Index intervention work identify readmissions as a contributing cause of poor Potentially Avoidable Complication rates or cost performance, the teams have the ability to join



forces in order to analyze, identify and develop complementary initiatives or interventions to improve performance.

- 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](#).

II. Overview of Intervention

1. Name of Intervention: SDOH Screening and RAE 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

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)

PROPOSED INTERVENTIONS & DESCRIPTION

SDOH Screening & Care Coordination Action Plan

**Focus Area - Core Populations
SW-CP1: Social Needs Screening and Notification**



The SCL Health Care Management Team, working closely with each HTP Site Steering Committee, will lead the development of the Social Determinants of Health (SDOH) Screening & Care Coordination Action Plan, the goal of which is to support the successful implementation of the following interventions:

1.) Development of an updated and streamlined system-wide case management and utilization management workflow that supports evidence-based practices and data-driven decisions in the delivery of patient-centered care by improving the efficiencies and accuracies in the following processes:

- Identification of at risk patients based on evidence-based criteria
- Collection of actionable and reliable data that can be used by care teams to inform everything from clinical treatment plans to discharge planning and transitions of care
- Improved and aligned care coordination by skilled case managers who can be more efficiently alerted by nursing care teams when a patient's needs include additional support services and coordinated care plans
- Improved and aligned post-acute care plans that improve transitions of care and limit unnecessary lengths of stay (LOS)
- Identification of community-based resources and health system-based resources, which support the treatment plans and goals established by patients, their families, caregivers, and clinical care teams

2.) Work with HTP Core Team as well as HTP Site Steering Committees to determine the feasibility and cost-effectiveness of technological upgrades, built primarily around the existing EHR platform, that streamline, and possibly automate, identification of at-risk patients for case management teams, payers, and others such as Regional Accountability Entities (RAEs), who are also charged with overall care management for Colorado's Medicaid Members.

3.) Identify and implement opportunities to leverage existing technology platforms in order to improve quality, integrity, and usability of data, including claims data managed by RAEs using Prometheus and other claims databases.

4.) Work with HTP Core Team and HTP Site Steering Committees to assess the availability and capacity of community resources, as identified by the Community Health and Neighborhood Engagement (HTP) process, the Hospital Community Benefits Accountability (as required by state law), the Community Health Needs Assessment process (as required by the Affordable Care Act), as well as the Community Health Improvement Plan (part of Healthy People 2020), in addition to other evidence-based health needs assessment that may be developed by local and state public health agencies, community health advocacy organizations or local and state government agencies.

5.) In partnership with RAEs and community organizations, leverage data gathered from improved reporting and streamlined workflow, complete a gap analysis in order to identify specific gaps in community-based resources, and develop sustainable strategies to address shortages or gaps in resources and support.

6.) Maximize system level upgrades and streamlined workflow interventions to enable robust reporting in support of the relevant interventions identified in other focus areas, such as readmissions reduction efforts, improved transitions of care, and LOS interventions.

TARGET POPULATION



The target population for this measure is all patients. All patients should be evaluated for social determinants of health (SDOH) factors. Findings from the CHNE and hospital data for Good Samaritan Medical Center reveals individuals experiencing homelessness are high utilizers and may be a population of focus for this measure. The CHNE also identified education disparities as a significant SDOH concern, with a high percentage of adults not having completed high school or a high school equivalent. Medicaid patients that screen positive for needs after being screened for social determinants will be targeted for interventions such as RAE referrals and connection to community-based resource services.

NOTES & DEFINITIONS

Social Determinants of Health (SDOH): National experts review the societal, physiological, and environmental factors that evidence indicates can serve as root causes in impacting overall health status for individuals, as well as communities. Literature summaries for most recent categories of SDOH can be found here: [Social Determinants of Health Literature Summaries - Healthy People 2030](#)

Status Update on RAE Partnership on Notification:

In advance of this proposal, SCL Health reached out to each RAE and requested an opportunity to discuss how we can work together to achieve the goals outlined in this focus area. Time constraints, and obvious operational impacts caused by COVID-19, prevented us from presenting a more complete outline of the health system-RAE partnership.

SCL Health and each of the RAEs are actively discussing and determining the bilateral needs required to successfully implement an enhanced SDOH screening tool and referral process. Regularly scheduled discussions will continue between each RAE and SCL Health over the course of the next year to discuss how we could collaborate to create a streamlined referral and notification process contemplated above. In order to make meaningful progress in preventing avoidable hospitalizations, health care systems will require assistance “upstream” from those entities who are likely to be aware of a patient’s health care needs well in advance of their first visit to the hospital or emergency department.

If this initial collaboration proves successful, we propose to expand the partnership in support of establishing a Joint Operations Committee (JOC), which could meet regularly to continue coordinating our respective efforts on additional HTP focus areas and interventions.

INTERVENTION & CONNECTION TO HTP GOALS

If successful, the evidence-based interventions outlined in this section should result in progress toward larger HTP goals, including improved access to appropriate care and treatment, reduced hospital utilization and readmissions. Most importantly, these interventions will improve the overall health outcomes of patients, reducing the need for acute care.

Not only are these interventions tied specifically to the focus area “SW-CP1: Social Needs Screening and Notification,” the improvements in care that will likely result from these interventions could potentially benefit a number of other focus areas, including those targeting transitions in care and reductions in readmission rates. While HTP rests under the jurisdiction of HCPF, the improvements made in screening and identifying at-risk patients and populations can be used to support population



health work being led by local public health officials and the Colorado Department of Public Health and Environment.

The enhanced SDOH screening and RAE referral processes will build on our existing foundation of work in these areas. The enhancement screening tool will allow the inclusion of additional SDOH domains, better data collection, and thus better reporting.

Currently, hospital-level communication with the RAEs is inconsistent and lacks any formalized process that involves evidence-based goals, measures or targets. Communication to date centers around prior-authorization requests and outreach to ensure a proposed treatment or medication is a covered benefit. The proposed RAE notification process will help to bring attention to patients needing support services and coordination that might not have already been identified by a RAE. Even if a RAE has flagged a patient as at-risk based on specific SDOH criteria and has already communicated that information to the provider officially designated as the lead provider (via attribution process), there are no guarantees that the hospital providing the acute or emergent care is aware of this information and vice versa.

Assuming that technology-based solutions, such as building the screening process into the EHR platform, prove to be cost-effective to create and implement, we are optimistic that the streamlined workflow, including automatic notifications for RAE referrals, will maximize efficiencies and achieve another one of HTP's goals to control costs related to acute 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)

The most recent round of Community Health Needs Assessments were completed by each of SCL Health's care sites in 2018; planning is already underway for 2021. NOTE: Additional background information related to that process can be found below.

SDOH, as well as other critical data involved in population health issues, are a centerpoint of that work. Access to quantitative data related to SDOH factors in addition to health conditions and outcomes, allows healthcare providers to better identify how to prioritize support for high-needs patients and high-needs communities. The process of identifying community health needs, gaps in resources, and systemic inequities highlight how social determinants of health (SDOH) can disparately impact health outcomes. Each CHNA incorporates population health data for counties that are identified in their primary and secondary service areas in addition to patient care data aggregated from EPIC, SCL Health's electronic health record platform.



NOTE: This data currently provides only diagnosis codes, insurance status, and other information commonly found in an EHR.

The Community Engagement process also allows hospitals and health systems to collect qualitative data from community members who use data-based conversations and public meetings as a way to share their personal experience relative to the data and ensure their narrative is part of that feedback process.

Patient-centered care requires health care systems to provide individuals with care and treatment plans tailored to meet their unique needs and their own personal care and health goals. We typically find common challenges and obstacles among several members who live in or identify with a community. The community engagement opportunities can be used to proactively identify common themes and common needs in order for care sites to take proactive steps to address barriers and challenges, especially where health equity concerns are raised.

Background: Community Health Needs Assessments (CHNAs)

SCL Health makes every attempt to align the metrics and data points with broader population health goals, such as those established by the Healthy People process managed by the U.S. Department of Health and Human Services, as well as those established by local health departments and the Colorado Department of Public Health and Environment per the 2008 Colorado Public Health Act. Information gathered as part of this process also informs our input provided to CDPHE and local health agencies who prepare Community Health Improvement Plans (CHIPs).

Recognizing that each community faces its own unique challenges and needs, the process is intentionally designed to “make room” to include site-specific needs and factors, such as those created by neighborhood gentrification efforts, localized industrial pollution, regional transportation projects, food deserts, or economic development/urban renewal efforts.

There are more than 45 different SDOH factors that cover more than 20 different societal, emotional, environmental or physiological conditions. SCL Health uses the CHNA process to use relevant data and identify the most prevalent or impactful factors that are impacting health outcomes in our communities. This SDOH intervention could inform future CHNA efforts, as it has the potential to provide care-site and system-level data, which highlights the impact SCL Health’s care sites and clinics are having on addressing risk factors and improving health outcomes.

The CHNA process extends over several months and includes intentional outreach to community leaders and community members to share the data analysis results, and solicit feedback and ideas on how we can better align the care we provide with the health needs identified by a community. The final “Community Health Needs Assessment” (CHNA) report is made publically available on our website as well as through community partners. Each care site works in partnership with local public health agencies, community partners and local leaders to review and analyze data, identify newly emerging gaps in care and progress in closing gaps identified by previous CHNA efforts. The Affordable Care Act requires that these comprehensive, data-driven reports be updated every three years.

In theory, every hospital, regardless of their governance model, should be using CHNAs to guide their investments in communities, however, only tax-exempt hospitals are required to document these investments in annual reports and annual tax filings submitted to the IRS (known as Schedule K, Form



990). Tax-exempt hospitals are also required by state law to hold public meetings each year to review the investment information with community members and to submit annual reports through the Hospital Community Benefit Accountability initiative summarizing these investments and community outreach.

NOTE: Social distancing requirements and public health orders limiting in-person gatherings prevented in-person public meetings in 2020; meetings were held virtually using ZOOM and public feedback was solicited electronically.

According to CHNE findings, housing is a significant issue region-wide, with almost a quarter of residents using half or more of their income on rent. Additionally, education disparities are a factor, with nearly 10% of the region's adults aged 25 and over not having completed high school or a high school equivalent.

Trauma was also referenced as a significant issue experienced by many of the HTP priority populations, especially individuals experiencing homelessness and individuals with behavioral health and/or substance use concerns. These experiences impact an individual's ability or willingness to proactively seek care in lower-acuity settings, potentially resulting in increased need for emergent care that must be addressed in emergency departments or inpatient units and not outpatient or community-based care.

Community stakeholders for this measure include: Sister Carmen Community Center, Office of Employment and Workforce Development, Catholic Charities, Colorado Coalition for the Homeless, Colorado Housing Authority, and Broomfield County Public Health. Other agencies will be engaged as appropriate.

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)

SUMMARY OF RESEARCH & EVIDENCE -BASED PRACTICES

The foundation for this work is based on evidence from best practices, targeted trials, and emerging practices from the following resources that help to determine social determinants of health and implement best practices for address them:



The federal government defines Social Determinants of Health (SDOH) as “the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.” [Social Determinants of Health - Healthy People 2030 | health.gov](#)

These evidence-based criteria are critical factors when trying to identify how existing inequities can impact an individual’s overall health status and quality of life. For hospitals, the dire consequences of systemic health inequities appear in the form of individual patients disproportionately suffering from debilitating (even fatal) heart attacks, strokes, respiratory distress, and chronic kidney and liver diseases. Literature summaries for most recent categories of SDOH can be found here: [Social Determinants of Health Literature Summaries - Healthy People 2030](#)

The underlying conditions often go undiagnosed, untreated or uncontrolled due to disparate access to health care and health insurance. The data are clear: communities of color and other marginalized and under-represented communities suffer from chronic health conditions at disproportionately high rates. These disparities have become even more evident during the current COVID-19 pandemic.

The American Case Management Association states that the ability to address the Social Determinants of Health depends on the providers ability to screen effectively. While most social determinants can be addressed by existing community resources, SDOH are often not factored into current healthcare processes. In the HTP measure work, SCL Health will address these barriers and update the screening tool, referral, and notification processes.

Through the CHNE process, it was identified that Social Determinants of Health can hinder a person's ability to engage in their healthcare, thus leading to worsened healthcare conditions and outcomes. Challenges with any SDOH may result in an individual prioritizing meeting their basic needs, such as food needs, shelter insecurity, or transportation conflicts over their health. If attention to these core areas or well-being is ignored, underlying health conditions can worsen.

Health outcomes associated with housing instability include respiratory and cardiovascular disease from indoor air pollution. These diseases account for some of the hospitals’ highest cost and utilization conditions according to the State’s Medicaid data for SCL Health. Housing instability can cause illness and death due to weather extremes, accelerated spread of communicable diseases, such as COVID-19, and higher risk of at-home injuries.

Food insecurity can lead to a greater risk of diabetes and hypertension. These are two of the highest cost and utilization conditions shown in the State’s Medicaid data for SCL Health. Food insecurity can also put children at higher risk for hospitalization and cause higher weight gain in pregnant women.

Lack of transportation can lead to inaccessible healthcare services, prescriptions, and healthy food, all of which escalate the other determinants. Lack of financial stability and utility security can lead to a dangerous living environment, including lower levels of sanitation that can accelerate medical conditions. Interpersonal violence can physically impact a person for the rest of their lives along with deteriorating one’s emotional health (American Academy of Family Physicians, 2019). For these reasons, it is important that SCL Health develop a more robust screening tool and process for addressing the Social Determinants of Health.

RESOURCES & REFERENCES:



Social Determinants of Health, Guide to Social Needs Screening (2019). American Academy of Family Physicians. The EveryONE project, advancing health equity in every community.

The CDC has reported that identifying a patient's social needs will determine their risk of returning to the hospital. If the risk is identified and interventions are made, such as referrals into the appropriate community resource, then, in the transition from the emergency department into the post-acute care, the risk of readmission would be less. A system-wide screening tool and process increases awareness and contributes to the likely success of a screening process and the identification of needs improving patient outcomes.

Wallace AS, Luther B, Guo J, Wang C, Sisler S, Wong B. Implementing a Social Determinants Screening and Referral Infrastructure During Routine Emergency Department Visits, Utah, 2017-2018. *Prev Chronic Dis* 2020;17:190339. DOI: <http://dx.doi.org/10.5888/pcd17.190339>

Berkowitz et al. brought up an important outcome of a SDOH screening, care coordination, and the patient connection to needed community based resources that the process has the potential to reduce acute utilization, reduce readmissions, and thus lowering the total cost of care. These outcomes are the desire of the Hospital Transformation Program and with a robust network of community resources we should see improvement in these areas.

Berkowitz et al. (2018) Association of a Care Coordination Model With Health Care Costs and Utilization: The Johns Hopkins Community Health Partnership (J-CHiP) *JAMA network open*. 2018;1(7):e184273. Epub 2019/01/16. doi: 10.1001/jamanetworkopen.2018.4273. PubMed PMID: 30646347; PubMed Central PMCID: PMC6324376 Medicare & Medicaid Services.

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)

SDOH screening, combined with a coordinated effort to notify RAEs when patients are flagged as being “at-risk” or when known “at-risk patients” are admitted to the hospital, supports the most foundational elements of the Accountable Care Collaborative (ACC). The ACC’s work of connecting Medicaid members with “right care” and providing patient support by coordinating healthcare services across multiple healthcare sectors relies on being able to also identify which additional support services are necessary when SDOH screenings surface additional barriers to care.

If SCL Health successfully creates and operationalizes a streamlined case management workflow, which includes a notification system to alert RAEs of patient visits to hospitals, including emergency department visits, the work could serve as a model that the ACC could support being implemented on a statewide basis. The aggregated data collected by the workflow could also inform data-driven conversations that would contribute to the community needs assessment work.

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)

Given SCL Health’s mission-driven work to improve health outcomes for not only individuals but also the communities we serve, SCL Health providers have extensive experience in screening patients for case management needs. Each care site and units within each care site are responsible for identifying SDOH risk factors and reaching out to case management teams to identify resources and supports.

A streamlined workflow that is expressly tied to evidence-based criteria, such as SDOH, will create continuity across the system, which ultimately ensures greater equity in how we identify at-risk patients and connect them with available resources beyond the healthcare system

Currently, when patients provide affirmative responses to direct intake questions related to behavioral health, SUD, abuse/neglect, cognitive function status, the nurses’ intake screening generates an automatic referral to case management.

Case managers additionally screen patients for high risk social and medical criteria, assess for post-acute planning needs and refer to post-acute services and provide community resources. The best practice is to identify patients’ needs (housing, access to healthcare services and healthy food, follow up appointments) and to connect them with referrals prior to discharge. Local nonprofits and



other hospital systems currently partner with Aunt Bertha (an organization that connects people with social services and other referrals that people need access to) and 211 (United Way).

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)

While screening for risk factors connected to SDOH is a standard Case Management process, as outlined above, the SCL Health strategy will improve the process to make it more robust, add electronic capture and sharing of information, and improve RAE coordination through greater partnership. Additionally, SCL Health plans to invest in more advanced EHR functions that will capture, display and track SDOHs in a way that provides visual cues and information to all care team members. By capturing more information faster, SCL Health can react more timely and make more referrals to appropriate resources.

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	Organization’s Role in Intervention Leadership and
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		partnering with this organization? (Yes or No)	Implementation (high-level summary)
CCHA	Regional Accountable Entity	Yes	Coordinated referral process

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](#).

II. Overview of Intervention

1. Name of Intervention: Collaborative Discharge Planning and RAE 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-BH1

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



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

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

PROPOSED INTERVENTIONS & DESCRIPTION

Collaborative Discharge Planning Process and RAE Notification Action Plan

**Focus Area - Behavioral Health and SUD
SW-BH1: Collaborative Discharge Planning Process and Notification**

The HTP Core Team, working closely with existing Care Management Teams, Behavioral Health Teams, and HTP Site Steering Committees, will lead the development of a Behavioral Health Improvement Action Plan that will meet the following objectives:

- 1.) Identify cost-effective, evidence-based strategies that can be implemented to ensure that when patients who are identified as at-risk due to a behavioral health diagnosis and/or Substance Use Disorder (SUD), can receive targeted support, including provider referrals, treatment options, medication, and/or access to community resources, upon discharge from acute care or emergency department care.
- 2.) Building upon existing partnerships and community engagement work, support HTP Site Steering Committees in the identification of opportunities to establish and implement innovative partnerships with behavioral health providers, RAEs, community-based organizations, local and state public health agencies, especially as the state’s Behavioral Health Task Force finalizes its final report and recommendations.



3.) Work with SCL Health clinical leaders to ensure that system-level infrastructure and supports align with evidence-based practices in behavioral health and SUD treatments; in addition to working closely with Care Management teams, Behavioral Health teams, ITDS, Informatics, Utilization Management, and SCL Health Philanthropy to identify process improvement opportunities.

4.) support HTP Site Steering Committee in the identification of evidence-based practices that can be cost-effectively established in response to behavioral health and SUD treatment needs that surface as part of Community Health Needs Assessments, community engagement and mission integration work.

TARGET POPULATION

The target population under this measure intervention will be the Medicaid patients that have a behavioral health and/or Substance Use Disorder (SUD) diagnosis on file. The target population will receive interventions such as referral to the RAEs for connection to the behavioral health network and benefits, and to post-acute behavioral health and SUD providers. Data for Good Samaritan Medical Center shows that Medicaid patients with higher utilization and cost of care due to over utilization are those with an alcohol abuse and dependence diagnosis. Feedback from community partners identified seniors and the LGBTQ community as populations that are disproportionately underserved in the Good Samaritan Medical Center service area.

CONNECTION BETWEEN INTERVENTION & HTP GOALS

The statewide measure identified by HTP in SW-BH1 is just one aspect of ensuring health systems are adequately meeting the needs of patients whose healthcare needs include behavioral health treatment and support, such as SUD treatment and recovery support.

The variety of acuity levels of behavioral health needs are diverse and unique as each patient and their individual circumstances. It will be imperative that the clinical interventions related to this measure take into account the unique circumstances and health status of each patient and are implemented in a way that honors existing patient-provider relationships, treatment plans, the patient's own goals, and ethical or patient-safety issues that may arise.

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)



Behavioral health-related needs continue to be one of the top two needs identified as part of SCL Health’s community engagement work. Each of the care site’s 2018 CHNA reports identify specific behavioral health needs for the communities we serve, as well as additional factors (SDOH, etc) or community characteristics that may be contributing to the frequency and/or acuity in behavioral health conditions.

The data collected as part of the 2018 CHNA process provides each care site with the community-level conditions that are impacting the overall social and emotional well-being of its community members. HTP Site Steering Committees, working alongside SCL Health clinical leaders and system-level care support teams, are already using the information provided in these assessments to inform which community partnerships and engagement opportunities may have the greatest impact for our patients and the communities in which they live and work.

The opportunities that are developed as a result of this process must take into account that, while health indicators and metrics such as “elevated rates of anxiety and depression caused by financial stress” may have common physical and psychological manifestations, the root causes driving health needs in different communities may widely vary. Financial stress created by job loss, economic downturns or low wages, is different from financial stress caused by catastrophic events, such as COVID-19 or natural disasters. Financial stress created by an inability to afford cost sharing obligations included in high-deductible health plans is different than either of the previous situations mentioned.

Caregivers and case managers work directly with patients to identify the unique circumstances that create each individuals’ health needs; CHNAs and community engagement efforts can help identify unique circumstances within each community that serve as root causes or factors that exacerbate existing inequities, vulnerabilities and health needs. Several of Good Samaritan Medical Center’s community partners noted the limited behavioral health services available to community residents. Provider to resident ratio is low (including certified addiction counselors) and availability is filled quickly, regardless of increased service capacity. The LGBTQ community is disproportionately underserved, along with individuals experiencing both behavioral health and physical health concerns.

Another vulnerable population identified in the CHNE was seniors. Seniors may often be perceived as having their care and social needs met, but they are frequently underserved. They may also be reluctant to engage with the behavioral health system for ongoing support, or they may not know how to connect with these services. They and their families/caregivers need greater care navigation and supports.

Based on community engagement efforts, clinical research, and policy research, it is almost certain that this process will surface issues that are beyond the scope of HTP, even state legislators and regulators. For instance, existing behavioral health work is routinely delayed or hampered by barriers created by self-funded, ESI (regulated at the federal level) health plans. For instance, plan administrators routinely reject claims related to prescription medication and in-patient treatment options, especially when patients are attempting to access SUD treatments. That said, the information gathered by this process can hopefully help inform reform efforts to address those barriers and challenges.

Partners for this work include Community Reach Center, Mental Health Partners, West Pines, Salud Family Health, and Clinica.



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)

SUMMARY OF RESEARCH & EVIDENCE-BASED PRACTICES

The intervention for this measure is aimed at creating access and continuity between care settings and involves the connection of patients to their benefits and behavioral health network through the RAEs. The evidence base for this work lies in best practices from leading organizations in this field. The best practice evidence shows that building systems that support patient needs through their care continuum while allowing providers and care managers to share information along the way can address gaps and patient needs. Through community engagement, it was learned that local healthcare systems can be fragmented around behavioral health services between provider and care management agencies. Therefore, creating processes based on best practice in order to break up the siloes amongst providers, systems, and current processes are highly desired to reach measure goals and community needs. Since the passing of the Affordable Care Act and the dollars allotted to models such as Accountable Care Organizations and Collaboratives such as Colorado's Medicaid RAE model are an emerging practice to manage cost and improve quality. An aspect of this model is the collaboration and partnership between the model entity such as the RAE, and all facets of the healthcare system including providers acute and ambulatory.

Best practice evidence can be seen through the following references:

REFERENCES

Lowell, Kristina Hanson; Bertko, John FSA The Accountable Care Organization (ACO) Model: Building Blocks for Success, Journal of Ambulatory Care Management: January-March 2010 - Volume 33 - Issue 1 - p 81-88 doi: 10.1097/JAC.0b013e3181c9fb12

The Impact Of Medicare ACOs On Improving Integration And Coordination Of Physical And Behavioral Health Care. Catherine A. Fullerton, Rachel M. Henke, Erica L. Crable, Andriana Hohlbauch, and Nicholas Cummings. Health Affairs 2016 35:7, 1257-1265

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)

Accountable Care Collaborative: The behavioral health metrics align closely with the Key Point Indicators (KPIs) that are already part of ACC's payment reform work in ambulatory settings. Information gathered as part of HTP can likely be used to inform and support implementation of capitated behavioral health contracts between the state Medicaid program and RAEs.

Governor's Behavioral Health Task Force (BHTF): Among the many goals outlined in the 2020 report is one that seeks to create timely access to care pathways. The BHTF report also calls out poor communication between provider and patient as a barrier to better care and treatment.

IT Roadmap: Data-driven decisions rely on actionable and reliable data. Systems designed to support information sharing, including the availability, accuracy and integrity of data, continue to be misaligned, misinformed or outdated, resulting in disjointed or incomplete information flows from



hospitals to outside entities, or the all-payers claim database (APCD), currently being administered by CIVHC.

Working in partnership with EHR vendors, technology stakeholders and other health systems, SCL Health will work to identify gaps in the current data flow process in order to identify opportunities for IT improvements and upgrades in order to improve the speed and accuracy with which patient care and claims data is collected and transmitted to the appropriate providers and entities. SCL Health intends to leverage the opportunities that arise as part of the HTP work to identify not only barriers to improving data integrity and reliability challenges but also to propose opportunities where health care IT systems can engage and support collaborative efforts to implement critical reforms to state-managed IT systems.

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)

EXPERIENCE CONNECTED TO INTERVENTION

Our community Behavioral Health organizations have a vested interest in providing their patients with the services they need to maintain their mental well-being. SCL Health's experience is the current process of identifying patients with behavioral health needs and referral to the most appropriate post-discharge resource and provider that addresses both inpatient and outpatient recommendations for mental health needs and substance use disorder treatment. Patients should be asked if they are currently under the care for behavioral health issues and contact should be made with that organization prior to discharge or for more detailed patient history. SCL Health has two behavioral health facilities, one on the Front Range, and one on the Western Slope. These facilities offer substance use disorder treatment, inpatient and outpatient services, addiction and substance use treatment, and mental health services for a variety of needs, such as depression, anxiety, post-traumatic stress, schizophrenia, and more. Both of these clinics openly accept Medicaid patients and work to fill provider gaps in the community.

SCL Health staff sit on boards across the State of Colorado to engage in conversation and bring expert opinion to break the barriers identified in behavioral health services. The engagement and commitment to the development of the behavioral health system is embedded in the work that SCL Health does every day. The most apparent barrier that this measure will address is the coordination between hospitals and the RAEs to improve the patient flow through their care path. The measure initiative will lead to identification of patients that need in-depth care coordination services, and connection to Medicaid's behavioral health network through the RAEs.

8.

a. Is this an existing intervention in use within the hospital ("existing interventions" are those interventions the hospital has implemented or is implementing on the day it submits the Hospital Application)?

Yes

No



b. If yes, please use the space below to explain how the following criteria for leveraging existing interventions is satisfied (the response may reference answers above):

- The hospital must demonstrate that the use of the existing intervention is the best approach for meeting the needs of the community identified during the Community and Health Neighborhood Engagement process.
- The hospital must demonstrate that the project will be enhanced to meet HTP goals.

Response (Please respond as applicable; Please seek to limit the response to 1,000 words or less)

9.

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

- Yes
 No

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

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

Partner Organization Name	Type of Organization	Does the hospital have any previous experience partnering with this organization? (Yes or No)	Organization’s Role in Intervention Leadership and Implementation (high-level summary)
CCHA	Regional Accountable Entity	Yes	Coordinated referral process

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](#).

II. Overview of Intervention

1. Name of Intervention: ALTO and Opioid Safety
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-BH3

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)

PROPOSED INTERVENTIONS & DESCRIPTION

Alternative to Opioids (ALTO) Action Plan

Focus Area - Behavioral Health and SUD SW-BH3: Using Alternative to Opioids in the Hospital ED's

The HTP Core Team, working closely with each HTP Site Steering Committee and system-level clinical leaders, will ensure the creation and implementation of a plan that advances the current efforts of the "ALTO in the ED" pilot program in order to achieve the following objectives:

- 1.) Build on progress to-date that ALTO in the ED pilot has had relative to decreased exposure to opioids by leveraging ALTOs as first-line treatment during a patient's visit to the emergency room.
- 2.) Identify opportunities to improve care plans by modifying doctor orders and providing decision support to alternative methods of pain treatment. The enhancements could come through additional pain pathway identification and pain point triggers that align with the appropriate use of ALTOs.
- 3.) Leverage technological resources to develop a dashboard that will be used by care site-level leadership, as well as system-level leadership to assess (at least on a quarterly basis) progress being made on identified benchmark metrics (TBD); coordinate with Quality and Safety teams to review ALTO program goals with existing metrics.
- 4.) Evaluate current data through ODHIN (CHA's dashboard) and share with care sites for frequent and transparent reporting on targeted performance improvement activities. Identifying lessons learned when engaging pain treatment specialists (anesthesiologists, as well as PAs and nurses with enhanced training).
- 5.) While monitoring is important, equally important will be the development of a performance improvement plan and to have in place any needed steps to correct performance fallouts. This work includes any modifications needed to the governance structure at System offices, care sites, and across services lines as HTP program years progress. Other performance improvement activities could include ED prescribing procedures, pharmacy engagement, patient medication delivery, and follow-up plans to increase the use of pain medication specialists (as needed).
- 6.) Engagement with Marketing and Community Benefit to identify opportunities to share the ALTO work information with the public. This work would support opportunities to improve health literacy and facilitate robust conversation from a place of an inclusive understanding on the topic and solutions.
- 7.) Engagement with CHA and the Colorado Chapter of American College of Emergency Physicians to assess effectiveness of training and implementation efforts of procedures that can reduce or negate the need for opioid use, such as pain point trigger injections, peripheral nervous blocks,



NSAIDs. These engagement opportunities will be used to learn and share best practices across our provider communities.

TARGET POPULATION

The target population for this measure intervention work will be patients in need of behavioral health services. Any patient presenting in the ED requiring pain medication for an identified pain pathway that has been determined as an appropriate use of alternative pain medications to opioid medications will also be a population of focus. Medicaid data shows that at Good Samaritan Medical Center substance use and dependency is a high cost utilization episode. Developing strategies for youth and young adult substance use prevention is an area for opportunity to be addressed through this measure.

CONNECTION BETWEEN INTERVENTION & HTP GOALS

To use Alternatives to Opioids and maintaining high levels of compliance to this program is important to reduce opportunities for exposure. Having less exposure would ultimately reduce those with opioid addictions. Including the use of alternatives to opioids in the ED as a mandatory measure for HTP is an appropriate step in order for hospitals to play their part in the role of helping to prevent the furthering of this epidemic. Now more than ever it is important that all sectors of the healthcare system come together to reduce opioid exposures, as hospitals could do, and that patients have access to a system which promotes the usage of pain medication responsibly. This measure promotes a fundamental measure to not only SCL Health but to HTP, which is promoting quality in healthcare and giving care that promotes the very best health outcomes.

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)

During the Community Health Network Engagement (CHNE) portion of the HTP program, we continually heard the need for a coordinated system to address addiction and that action needs to be taken to stop the opioid epidemic that is plaguing our families and communities.

The ALTO work that we started last year at SCL Health does just that and makes for natural alignment for HTP intentions to improve healthcare outcomes. SCL Health's ALTO rollout was happening at the same time as the CHNE process and addresses many of the opportunities the community expressed as a need throughout this process.

The ALTOs in the ED measure highlights the role the hospital can take in the community fight against opioids. The intervention work has shifted ALTO use from its primary role of being incorporated to



addiction treatment to a promising role in not only effectively managing trauma-related pain. but also in actively reducing the risk of addiction faced by patients who are exposed to opioids in settings such as EDs and dentists' offices.

SCL Health recognizes the coordinated effort needed to approach opioid addiction. The effort must be community-wide and SCL Health, along with other health systems and hospitals, have an obligation to share best practices. Should the Colorado Health Care Collaborative (an affiliated group of Colorado's largest health systems currently focused on a collective response to COVID-19 across the state) continue its work beyond the COVID-19 response, the Collaborative, or other initiatives, could help facilitate systems sharing data and best practices in order to further refine our approach to reducing opioid exposure, which we expect will reduce opioid addiction and related SUDs. RAEs, as well as other payers, play a critical role in ensuring that ALTOs qualify for reimbursement and do not require prior authorization. Community stakeholders include but are not limited to: SUAG (Boulder County Public Health, substance use resources, strategies, etc.), HFC (youth/young adult substance use prevention), Mental Health Partners (mental health services, referrals, etc.), Community Reach Center (mental health services, referrals, etc.), Colorado ALTO Project (opioid safety pilot through Colorado Hospital Association), and Northern Colorado Health Alliance. Additional partners will be engaged as appropriate.

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)

The evidence base for using alternatives to opioids in the hospital setting comes from multiple sources which consist of best practices and emerging practices through frameworks and toolkits backed by randomized control trials and descriptive information. The evidence informs SCL Health on how to roll out a program for using alternative pain medications in the hospital settings. Additional work and engagement is done through CHA to share best practices amongst different hospitals in Colorado which allows for the sharing of best practices to be seen through a local lens. The references for ALTO work include:

Best practice references:

[CDC Guideline for Prescribing Opioids for Chronic Pain, 2016](#)



[American College of Emergency Physicians Opioid Treatment Guidelines, 2017](#)

CDC Training Module: [Module 2: Treating Chronic Pain without Opioids](#)

[Patients' memory for medical information](#)

Emerging practice references:

NIDA: [How can prescription drug misuse be prevented](#)

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6548151/pdf/AJEM-2-e45.pdf>

[Suicidality in chronic pain: a review of the prevalence, risk factors and psychological links | Psychological Medicine](#)

[Racial Disparities Limit Health Equity in Pain Management](#)

Descriptive information:

[Doctors And Dentists Still Flooding U.S. With Opioid Prescriptions](#)

AHRQ: [Guide to Implementing the Health Literacy Universal Precautions Toolkit](#)

NIDA Continuing Education Modules: [Discipline Spotlight: Pharmacists](#)

ODPHP: [Pathways to Safer Opioid Use | health.gov](#)

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)

The ALTO intervention is aligned with the following initiatives:

SUD Waiver Request: For patients who are already suffering from Substance Use Disorder (SUD) related to opioid exposure, health care providers should be actively coordinating efforts to increase opportunities for treatment while concurrently decreasing exposure. The work envisioned by the SUD Waiver aligns well with SCL Health’s concerted effort to assist community-based organizations getting patients who are working to connect patients, and in the case of Medicaid recipients with RAEs, in order to ensure that eligible patients are able to access health plan benefits related to SUD treatment and recovery.

Behavioral Health Task Force: Substance use treatment resources are at capacity and reducing the population that needs these services by the preventative work done through ALTOs in the ED will hopefully reduce the number of patients who are exposed and thus become addicted and ultimately reduce the number of patients needing ambulatory addiction services. As stated above this is a concerted effort to prevent addiction and to create access to interventions for those facing addiction, and to keep this work aligned and moving forward.

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)

SCL Health care sites and their providers have already invested significant resources for education, process improvement and change management associated with this intervention in the Colorado and Montana regions.

Alcohol (the most common DRG) use is determined upon admission. Good Samaritan Medical Center utilizes the Screening, Brief Intervention, Referral to Treatment process in the ED. Nurses screen



appropriate patients for alcohol and drug use and follow the process in order to identify and intervene with patients who might be at risk for developing more serious disorders.

Good Samaritan Medical Center operates a Medication Assisted Treatment (MAT) program to treat persons with an opioid addiction. The medications have been proven to stop drug cravings and shut off the effects of the opioids. The initial dose is given in the ED and then the patient is referred to a community-based MAT treatment center for continued treatment. The Boulder County SUAG is a resource for people dealing with addiction and for organizations looking for resources related to substance use.

SCL Health has sponsored the initiation of training and program guidance for the Montana Hospital Association and emergency medicine providers and will continue to collaborate when opportunities arise. This experience and our commitment to continuous improvement will support efforts to maintain the improvements and identify opportunities for incremental improvements to the ALTO in the ED programs, the ACEP guidelines, and patient outcomes.

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)

SCL Health has identified that the ALTOs in the ED initiative is the best work to address the measure needs, as a decrease in the use of opioids in the ED and increase the use of ALTOs in the ED are requirements of this measure.

SCL Health has continual good performance in using ALTOs in the ED and will continue that work with the goal of keeping ALTO numbers up where most appropriate and numbers down in using opioids for conditions where ALTOs can be used as the alternative.

SCL Health will create a dashboard for the hospitals to use to monitor their work. SCL Health will leverage the ALTO System Steering Committee and the hospital ED ALTO groups, which consist of leaders, clinicians, Quality, and Performance Improvement associates, to continue to meet regularly to review CHA’s ODHIN data and engage in bi-directional feedback to share best practices and examine opportunities and implement any changes to improve the outcomes of this work.

SCL Health will engage the Community Benefit department along with Marketing and Communication to strategize the best way to get information on our work out into our communities. SCL Health will



work in a collaborative manner with CHA and other Colorado hospitals to streamline processes and align with local initiatives and best practices.

- 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](#).

II. Overview of Intervention

1. Name of Intervention: Hospital Index-Care Redesign
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-COE1

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)

PROPOSED INTERVENTIONS & DESCRIPTION

Hospital Index - Care Redesign

Focus Area - Clinical and Operational Efficiencies
SW-COE1: Hospital Index



The HTP Core Team, working closely with existing HTP Site Steering Committees, will lead the development of the Hospital Index - Care Redesign Action Plan that will meet the following objectives:

- 1.) Establish a system-led process that engages physicians and nurses at all levels of the Care Redesign process including: Chief Medical Officers, Chief Nursing Officers and Medical Directors at each care site, professional practice committees, hospitalists, physicians who lead various service lines (i.e. Chief of Surgery and Chief Cardiologist at each care site), clinic physicians and medical group physicians.
 - 2.) Work in partnership with clinicians to formulate Care Redesign recommendations, which will then be reviewed and approved by HTP Core Team, HTP Care Site Steering Committees and system leadership.
 - 3.) Ensure that SCL Health's Care Redesign process is a data-driven initiative and results in evidence-based improvements to patient care by conducting comprehensive claims data analysis using data acquired from Prometheus and SCL Health's own business analytics department. The claims data analysis will include identification of root causes, patterns in patient utilization based on health condition and diagnosis and opportunities to improve clinical practices and procedures.
 - 4.) Identify opportunities to improve data integrity, which includes identifying gaps in data, delays in data being collected and transmitted and identifying irregularities that contribute to inconsistencies in data and work with RAEs. Continue to partner with state Medicaid leaders and EHR vendors to identify procedures to improve data quality and integrity.
- NOTE: The following have been identified as key metrics that require ongoing collection and monitoring: PAC score; total cost of care and individual cost components. Key metrics by provider include; readmits (by episode, by day, by discharge disposition); Length of Stay (LOS); discharge disposition; and overall utilization volume. Additional KPIs will be developed as data is received and evaluated.
- 5.) Develop policies and procedures that support continuous improvement of the program by measuring, tracking, and frequently reviewing and analyzing data in order to measure progress toward established program goals. HTP Core Team will work closely with SCL Health Operations and Transitions of Care Councils to ensure that educational opportunities are made available to HTP Care Site Steering Committees and that there are opportunities to support the sharing of best practices.
 - 6.) Identify feasibility and cost-effectiveness of creating and sustaining a potential care site-based Navigator Program that would serve to provide additional trained support to case management and hospital-based care teams in their implementation of HTP interventions, such as Transitions of Care, Length of Stay, Readmissions Reductions, and SDOH Screening.
 - 7.) Identify opportunities for the potential Navigator Program to support at-risk patients who are identified either by their engagement with HTP-related initiatives or based on factors that arise from SDOH, Readmissions, ALTO in the ED, and/or Behavioral Health screenings. Navigators could also be engaged in coordinating community resources as part of the Care Redesign process and/or communicating new interventions and process improvements.



8.) Identify opportunities to partner with community-based organizations and existing community partners in Care Redesign planning and implementation, including: referral process (i.e implementation of automated electronic means when possible, feedback loop on referral outcomes, etc.) and assisting with connecting patients with their benefits if they are not already accessing them.

9.) Identify opportunities to improve associate and clinician training by leveraging community partner training programs and training developed by provider organizations and federal agencies (such as ADE prevention training, patient health literacy training, etc).

TARGET POPULATION

The target population under this measure intervention will include patients seen at Good Samaritan Medical Center under certain episodes of care that SCL Health identifies as being a Potentially Avoidable Complication or cost. SCL Health will determine these episodes after analyzing the Prometheus data during the HTP implementation years.

CONNECTION BETWEEN INTERVENTION & HTP GOALS

To address total cost of care and Potentially Avoidable Complications (PAC), SCL Health's comprehensive intervention strategy will identify cost and other performance improvement opportunities, engage stakeholders in the design and delivery of interventions and leverage transition of care management resources and tactics. A combination of these efforts will ultimately result in higher quality of care for patients walking through our hospital doors.

SCL Health sees this as a cornerstone of the HTP intent and the program goals focused on improving patient care, creating meaningful engagement with patients and communities, and readying the hospitals for value based purchasing programs. Fundamentally, this intervention is designed to ensure patients are connected with the right care at the right time and that all involved are aware of the patient's needs and their role in supporting those needs.

Transformations in care cannot occur nor would they be sustainable without engagement from clinical teams, most importantly physicians and nurses. In order to effectively engage clinicians, SCL Health will ensure the development of reliable data will serve as the foundation of this work. Evidence-based practice requires access to actionable, reliable data based on a set of aligned measures. This process lies at the heart of HTP's program goals. Physicians require access to comprehensive, detailed, and reliable data in order to authentically engage in the Care Redesign Process. To date, state databases have not been able to provide the high-quality and reliable data required by SCL Health's Care Redesign team.

Improving coordinated patient care requires investment in resources, both technological and human, that provide critically needed support to at-risk patients and their clinical care teams. The Navigation Program would provide a critical set of services required, not the least of which is improved communication between patients, providers, and payers. For instance, Navigators could ensure that discharge summaries are transmitted to post-acute care providers in a timely manner, and work closely with care managers at RAEs to ensure patients are connected with resources available to support post-acute care, such as NEMT providers, home health care providers, etc.

Navigators would be able to leverage technological upgrades, resources, databases and community partner resources, to identify concrete steps that can be taken to remove the identified barrier to



discharge. Navigators, as SCL Health envisions the role, play a critical role in supporting increased patient health literacy so that patients can more effectively communicate their goals and desires to their care teams.

Continuous performance improvement is another cornerstone of HTP and also requires reliable and actionable data. SCL Health has developed a plan to meet the HTP measure for Hospital Index with an initiative that will address Potentially Avoidable Complications (PAC) and the “total cost of care” identified episodes according to the Department’s Prometheus dashboard.

Having access to relevant claims data cannot be overemphasized; claims data provides the best opportunity for root cause analysis of cost and quality improvement opportunities. Achievement of low Hospital Index Scores (per Prometheus) provides the SCL Health analytics team with opportunities to take “deep dives” into treatment and claims data in order to analyze and identify opportunities to positively impact the score. Since the Hospital Index Score is tied to a patients’ Potentially Avoidable Complication indicator on an episode of care, it will be important to work hand in hand with the State to validate data, clearly identify patients associated with poor PAC performance and tie these episodes in the Prometheus tool back to SCL Health’s EMR so that appropriate interventions can be applied.

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 intervention will address the cost and quality of care needs as articulated by the community and the State, which stipulate that healthcare costs need to be reduced and healthcare outcomes need to be improved. Gaps in resources will be identified through the process outlined above as the work will identify patients at higher risk for readmission or avoidable costly spends in patients with high healthcare needs that might be indicative of inefficiencies in the continuum of care, community resource gaps and/or health literacy opportunities, all of which impact our community partners. Going into this initiative, SCL Health’s working assumption is that we will identify potentially avoidable costs in care associated with avoidable complications, which would lower healthcare costs and/or assist in identifying gaps in care for patients.

This intervention will leverage post-acute partners to participate in care redesign and create continuity of care activities between hospital and follow-up care providers. We will leverage our network of local community resources and partners to steer patients through navigators to the most appropriate resource for their medical condition. For example, if a diabetic patient readmits to the hospital and they screen positive for food insecurity, it would be important to connect that patient to food resources, such as the county office to apply for SNAP benefits, to WIC if the patient is



pregnant, to local food banks, to the RAE for care coordination oversight and/or to any other resource path that would fill the gap the patient is experiencing. This path will look different for each patient and for each episode of care identified through the analysis of Prometheus data.

Partners for this measure include: ERAS-SCL Clinics (referrals post-surgery), Clinica (medical home, referrals), TRU Community (PACE, adult community center, transportation), Innovage (referrals post-surgery for older adults), local senior centers (education), Kaiser (medical home, referrals), Community Reach Center (mental health services, referrals) and Mental Health Partners (mental health services, referrals). Other agencies will be engaged as appropriate.

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)

The evidence base for guidance in intervention work for this measure is two part, one is that each episode included in the Prometheus dashboard has its own evidence based clinical guidelines according to the line of service and specialty of that service. Second, there is a body of evidence showing that to add value to health care one must increase care quality for less cost, which is the aim of the Hospital Index measure through the Prometheus database and measure requirements. SCL Health will take the approach to marry the two by looking at what Prometheus suggests and looking at the line of service's clinical best practices to identify opportunities to increase value in each episode identified as having a higher Potentially Avoidable Complications (PAC) score.

Evidence shows that best practices to increase value in healthcare includes the ability to collect and analyze data, as seen in the references below. This includes data that comes from claims, data derived from coverage/benefits, administrative processes and policies, and clinical data. This is necessary to the learning process in value based programs and addressing high cost and quality improvement initiatives. Data science is a fundamental component of population health and is being employed in the healthcare industry on an ever-increasing basis. The core of the Hospital Index measure intervention involves the use of episodic data to examine opportunities for improvement.

Leung TI, van Merode GG. Value-Based Health Care Supported by Data Science. 2018 Dec 22. In: Kubben P, Dumontier M, Dekker A, editors. Fundamentals of Clinical Data Science [Internet]. Cham (CH): Springer; 2019. Chapter 14. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK543518/> doi: 10.1007/978-3-319-99713-1_14



As an emerging practice, navigators can play an important role in transitions of care to reduce healthcare spend in readmissions, length of stay, and align acute and post-acute care, such as from Hospitals to specialty care or primary care. A navigation model ushers a patient through their care experience and typically gets good reviews from patients due to the hands-on nature of the model and patient engagement.

Forward, M., Kuzewycz, A., Little, S. Does Having a Nurse Navigator vs. Not Having a Nurse Navigator Decrease The Cost of Healthcare in Patients with a Sepsis Diagnosis? Philadelphia University and Thomas Jefferson University.

Zangerle, C.M. (2015). Nurses as Navigators. Nursing Management, October 2015; 27-28. Wolters Kluwer Health, Inc.

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)

The Hospital Index measure initiative aligns well with the Affordability Roadmap by addressing the cost of care by reducing Potentially Avoidable Complications. If trends in complications are addressed, the overall spend by the State for patients healthcare events under Medicaid should be reduced.

This intervention will strengthen the communication and continuity between hospital services and primary care services. This increased emphasis on primary care interventions will ultimately curve unnecessary acute care spending. Through this measure, SCL Health and state regulators will have the opportunity to examine what is driving high cost spending in healthcare, which is what the Roadmap is aiming to achieve.

The Hospital Index measure initiative aligns with the goals of the IT roadmap by using technology, both internal and through Prometheus, to identify opportunities to address inefficiencies, avoidable patient complications, and avoidable costs in healthcare. This is an important step towards leveraging data for predictive modeling and moving healthcare further in preventive care. Strides made by measures, such as the Hospital Index, will engage the acute providers into a proactive space instead of a reactive.

The goals of the Accountable Care Collaborative (ACC) align with this measure, given that RAEs, too, use claims data from Prometheus to identify opportunities to address inefficiencies and gaps in service. Although the use of the Prometheus tool is different for the RAEs than the hospitals, it will still activate hospitals to look at improvements associated with episodes of care for the Medicaid population and set internal Key Point Indicators on the hospital goals.

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)

SCL Health has been participating in two Medicare bundled payment programs under CMS' Center for Medicare and Medicaid Innovation (CMMI), Comprehensive Joint Replacement (CJR), and Bundled Payments for Care Improvement-Advanced (BPCI), which are both full risk programs that hold participants responsible for the total cost of care from "anchor hospitalization through 90-days post-discharge." Both of these federally administered programs seek to address, among other things, inefficiencies in the care continuum, poor outcomes and high cost.

SCL Health has been engaged in the CJR bundle for more than 4 years and BPCI for 9 months, however pre-program planning took 18 months; this work included robust data infrastructure development, development of a post-acute network, Transitions of Care strategies, risk stratification, and a Navigation program. SCL Health's Navigator Program related to both of these payment models have been recognized by CMS, including a request that SCL Health Navigators engage in efforts to train other hospitals how to effectively use this intervention.

8.



a. Is this an existing intervention in use within the hospital (“existing interventions” are those interventions the hospital has implemented or is implementing on the day it submits the Hospital Application)?

Yes

No

b. If yes, please use the space below to explain how the following criteria for leveraging existing interventions is satisfied (the response may reference answers above):

- The hospital must demonstrate that the use of the existing intervention is the best approach for meeting the needs of the community identified during the Community and Health Neighborhood Engagement process.
- The hospital must demonstrate that the project will be enhanced to meet HTP goals.

Response (Please respond as applicable; Please seek to limit the response to 1,000 words or less)

9.

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

Yes

No

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

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

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

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](#).

II. Overview of Intervention

1. Name of Intervention: Patient Flow-Severity Adjusted Length of Stay
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

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)

PROPOSED INTERVENTIONS & DESCRIPTION

Patient Care Workflow - Length of Stay (LOS)

**Focus Area - Population Health/Total Cost of Care
SW-PH1: Severity Adjusted Length of Stay**

Patient Flow work is guided by the mantra “right care, right place, right time.” Efforts to streamline and align Patient Flow must cover the full continuum of care. In other words, it begins with a patient’s admission to an acute-care setting, continues through discharge planning, and follows through the end of required post-acute care. Improving Patient Flow and addressing costly LOS issues require SCL Health to identify processes that address systemic barriers to care.

The Patient Flow Core Committee, working closely with HTP Site Steering Committees, will lead the effort to develop a system-wide implementation plan to improve and streamline the patient care workflow process in order to achieve the following objectives:

- 1.) Ensure that patients receive the most appropriate evidence-based care during their hospital stay by matching patients up with their most appropriate care path for their condition and acuity and match capacity and bed demand. Lastly, ensure that they are discharged to the most appropriate care setting for their medical condition in a timely manner.
- 2.) Leverage Patient Flow activities in order to improve LOS by identifying factors that influence it such as increase timely discharge, reducing delays, improving patient handoffs and transfers into the post-acute space, and enhanced communication. Through these activities, patient experience and outcomes will be improved.
- 3.) Develop strategies and implementation plans to address efficiency opportunities in all facets of hospital-based care, including the Emergency Department, inpatient and outpatient units and the post-acute care environments.
- 4.) Address patient care barriers through Care Management techniques that would shape and reduce bed demand such as primary care capacity, Social Determinants of Health, enhance communications with the patient’s post-acute care.
- 5.) Maximize available qualitative and quantitative data and dashboards to engage the appropriate analyses and tracking of efforts. A key performance metric for this work is Length of Stay (actual and



compared with CMS Geometric Mean Length of Stay; SCL Health will incorporate Medicaid LOS benchmarks, if provided). Data will be shared through dashboard reporting and provider engagement to create a feedback loop to target patient flow and LOS barriers that and provide data driven care redesign initiatives through HTP years.

TARGET POPULATION

The target population for work under this measure would be patient populations under Medicaid that have barriers to timely discharges and transitions of care support services, including safe post-acute recovery settings. This may include vulnerable populations presenting as high cost or frequent utilizers, especially for complex social cases. Individuals experiencing homelessness may also be a particular area of focus for Good Samaritan Medical Center.

CONNECTION BETWEEN INTERVENTION & HTP GOALS

The Patient Flow initiative is a way to match current demand by the industry to effect change with HTP goals while also furthering SCL Health's readiness for value-based reimbursement. The efficiencies of a Patient Flow process has a direct impact on the length of time a patient spends in the hospital. The most prevalent, and costly, delays occur when there are barriers to discharge caused by a lack of communication between hospital-based care teams or when communication challenges arise between hospitals and post-acute care facilities, such as Long Term Care facilities and Skilled Nursing Facilities (LTC and SNF). Delays in discharge are not only contributing factors to increased costs, they can also result in incidents that adversely impact the patient, such as increasing their risk of falling.

The measure initiative will focus on identifying appropriate care paths for specific medical conditions and acuity levels, inefficient work flows, and other determinants that contribute to a patient's length of stay. Overarching goals associated with Patient Flow align directly with HTP's overall goals. By improving Patient Flow and improving LOS metrics, SCL Health has an opportunity to achieve the most important goal, to improve the patient experience and outcomes.

Current work relies on accessible dashboard reporting to engage clinicians, providers and departments across SCL Health for both patient flow analysis and measuring new tactics and strategies. The results of this information will be used to align and streamline efficient workflow plans. This work includes the evaluation of data and dashboard functionality to identify data gaps and incorrect data flow paths and dashboard usage. An important byproduct of this intervention and analysis is to address provider burnout. Smooth and effective transitions will improve the environment for physicians and associates, which will improve provider engagement and retention.

System redesign work will bring together subject matter experts from all care sites to evaluate and and share patient flow experiences unique to each institution, allowing for the identification of best practices and new strategies. Such redesign activities will include engaging hospital staff to mold practices into opportunities as identified in the previous two tactics, synchronizing tasks, and post-discharge engagement. Once opportunities are identified processes will be updated. SCL Health's Enterprise Learning tools will be engaged and deployed as necessary to achieve adoption of new processes.

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)

Through Community engagement, it became apparent that the healthcare system lacks a way to communicate regularly and efficiently about patient care across the care continuum. There are gaps in communication and gaps in attention to patient needs after they are discharged from the hospital setting, which could be due to a multitude of reasons.

Through the Length of Stay measure and Patient Flow work, SCL Health will work to address those gaps by identifying the efficiencies in the patient's care path that could be caused by their hospital visit. Work through the Patient Flow Core Committee will be to increase communication and provide a consistent feedback loop across the system when patients seek care at SCL Health. When SCL Health starts to unpack the patient flow process and examine the components and identify inefficiencies, it could be discovered that patients have a longer length of Stay when certain conditions exist, such as Social Determinants of Health and addressing comorbidities associated with an acute medical condition.

It is possible that the inability to place a patient in a post-acute facility or to find community based services would impact the patient's length of stay, such as when discharging the patient is unsafe without the appropriate care option after discharge. This has been seen in the homeless population when oxygen is needed after discharge. If a homeless individual is prescribed oxygen for discharge and does not receive it, their safety and health outcome would be at risk. Doctors might opt to keep the patient in the hospital to ensure patient access to oxygen, which would prolong their length of stay and Patient Flow path. Barriers like this will be analyzed and solutions will be identified as part of the goals of Patient Flow.

Community partners for this work include: ERAS-SCL Clinics (referrals post-surgery), Clinica (medical home, referrals), TRU Community (PACE, adult community center, transportation), Innovage (referrals post-surgery for older adults), local senior centers (education), Community Reach (mental health services, referrals), and Mental Health Partners (mental health services, referrals). Additional stakeholders will be engaged as necessary.

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)

SUMMARY OF RESEARCH & EVIDENCE-BASED PRACTICES

Patient Flow improvement efforts are supported with best practice evidence as learned through such organizations as the Institute for Healthcare Improvement (IHI), which outlines the importance of reducing demand, shaping use, data usage, and strong leadership. The IHI work comes from two decades of research, innovation, and learning about hospital-wide patient flow.

Rutherford PA, Provost LP, Kotagal UR, Luther K, Anderson A. *Achieving Hospital-wide Patient Flow*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2017

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)

The Patient Flow work aligns with any State initiative that aims to create efficiencies in the healthcare system. Through the work to come, SCL Health hopes to identify specific episodes of care or services lines that might have more inefficiencies than others. For these reasons, it would be premature to call out an alignment such as pharmacy, or behavioral health, or ALTO work, because all episodes are under evaluation with this measure initiative.

For the time being, initiative work being done to align patient needs with the correct care system delivery method, such as the ACC, would be the best fit. Other initiatives that look at the transitions of care between different care settings, such as the Behavioral Health Task Force, would also align if the measure initiative work identifies inefficiencies in patients needing behavioral health services.

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)

SCL Health hospitals embarked on work associated with Length of Stay in 2019. The team engaged in this Length of Stay work gathered a great deal of data and created structures that afford the Patient Flow team a foundation to build upon and effect additional improvements. Leveraging the structure created under the early Length of Stay work will entail the use of a cross-functional multidisciplinary committee to steer the work, multidisciplinary rounding that creates the integration of a feedback loop of various perspectives and approaches and a data feed to include analytics and dashboard reporting.

Some of the data structure created allows SCL Health to track Length of Stay measures, including data by department to show impacts of service lines, data by medical provider to engage in provider accountability and feedback, by discharge disposition, the observed over expected length of stay statistics, and productivity such as patient to staff ratio and ability to respond quickly to volume changes.

The data structure additionally includes discharge orders, actual discharge, performance improvement action plan tracking, and meeting attendance to ensure engagement. While prior Length of Stay data structures and work will be leveraged for Patient Flow, there exists opportunities to build new resources, create more sustainable workflows and carepaths, and create more streamlined and efficient discharges, transfers and handoffs. Some of these opportunities include greater access for long-term care facilities to a hospitalist and other clinicians to avoid readmissions, advance directive discussions with a health care provider and providing access or a referral to hospice earlier in the care process. Improved communication with health care organizations and other partners (HIE, CORHIO, Care Everywhere, CCD) can help with complex care management coordination and care transitions. Discharge transitions can also be improved, such as “making



connections” for individuals rather than providing “lists of services” and improved physician to physician communication when moving between the hospital and LTC.

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 illustrated above, SCL Health began work on Length of Stay last year and the early work was narrow in scope - primarily focused on discharge planning. The Length of Stay work and enhancements in discharge planning led to the identified need for improvements in all aspects of Patient Flow. Work plans to expand and evolve Length of Stay work began in late 2019. Shortly thereafter, its overlap with HTP goals and opportunities were identified.

We are still at the beginning of Patient Flow work and goals will be put in place to identify and address gaps, inefficiencies, poor health outcomes, and readmissions. In addition to addressing length of stay, this intervention is likely to generate data and tactics that benefit other interventions, such as Hospital Index, Readmissions and Social Determinants of Health screening.

Furthermore, this goal of dissecting and improving Patient Flow will generate greater partnership with RAEs and community partners as their existing roles are evaluated and input from them is collected to help inform and shape new carepaths and transitions of care.

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.

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



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](#).

II. Overview of Intervention

1. Name of Intervention: Patients with Ischemic Stroke Discharged with Statin Medications
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. RAH4

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)

PROPOSED INTERVENTION AND DESCRIPTION

Patients with Ischemic Stroke Discharged with Statin Medications

Focus Area - Reducing Avoidable Hospitalization Utilization

RAH4: Percentage of Patients with Ischemic Stroke who are Discharged on Statin Meds (eCQM)

Stroke is a leading cause of death in our country. If a patient survives a stroke, it could be a leading cause of disability for that patient. SCL Health recognizes that the Medicaid population and populations living beneath the Federal Poverty Level have increased social determinants of health which induce stress. Stress can cause high blood pressure and bad cholesterol as can eating unhealthy food, a chance of which is increased when food disparities exist.

When SCL Health examined the Medicaid data sets provided by the State, it was apparent that hyperlipidemia/high cholesterol was one of the highest cost and highest utilization episodes for the Medicaid population at every SCL Health hospital. When reviewing HTP measures and the option to select Stroke was listed, it was decided that this work belongs in the Hospital Transformation Program as the Medicaid population has high utilization for hyperlipidemia that could lead to ischemic stroke and statin medications lead to lower levels of hyperlipidemia. The work of prescribing statin medications to those patients presenting with ischemic stroke has a great impact on our healthcare system. Statin medications will reduce the potential for short and long term disabilities caused by stroke.



Patients prescribed with statin medications upon hospital discharge are more likely to experience a lower risk of additional strokes and hyperlipidemia down the road along with lower risk of developing disabilities. Care sites will plan for the following objectives:

- 1.) Monitor Stroke data at regular intervals for a data driven approach for improvement and feedback. The Stroke coordinators will meet regularly to talk through data sets and identify barriers, best practices, and opportunities for success in this work.
- 2.) Patient outreach to ensure medication compliance post-discharge with possible outreach methods such as telehealth and EHR capabilities through the patient portal and options through telemedicine appointments. Sharing best practice in patient outreach will be discussed in regular meetings between stroke coordinators for learning opportunities that would further the streamlined approach to this work.
- 3.) Ensure that Medicaid beneficiaries are at the same System goal as private payers. Currently, Medicaid beneficiaries fall slightly under the compliance rate that private pay patients hold.
- 4.) Create and ready a performance improvement plan that includes a governance structure, process, and streamlined approach shall there be a compliance rate fall out.

Stroke work at SCL Health follows national measure recommendations and requirements to maintain the Stroke Center Certification. The American Heart Association/American Stroke Association (AHA/ASA) and The Joint Commission (TJC) define core measures for Acute Ischemic Stroke (AIS) Patients that are evidence-based best practices for optimal patient outcomes. These core measures are: STK-1) Venous Thromboembolism (VTE) Prophylaxis, STK-2) Discharged on Antithrombotic Therapy, STK-3) Anticoagulation Therapy for Atrial Fibrillation/Flutter, STK-4) Thrombolytic Therapy, STK-5) Antithrombotic Therapy by End of Hospital Day Two, STK-6) Discharged on Statin Medication, STK-8) Stroke Education and STK-10) Assessed for Rehabilitation (The Joint Commission, 2018). Compliance to STK-6 is shown to decrease readmission rates of AIS patients (AHA, 2018).

Each of the SCL Health Colorado Hospitals are certified stroke centers. Each hospital enters compliance data into a national database called "Get With the Guidelines" as a requirement for this certification. Therefore, the data collection process exists for monitoring compliance to discharging AIS patients on a statin medication. In 2019, 85% of total discharged AIS patients received a statin prescription and, so far in 2020, 91% have received a prescription for statin at discharge. While the data collection exists, there is opportunity to monitor compliance more closely and at regular intervals as a collaborative system. The goal of this measure initiative will be to maintain a 90% compliance standard across the system in aggregate. This benchmark exceeds the performance of the State of Colorado so far in 2020 (88%) and nationally thus far in 2020 (85%). Maintaining this level of compliance will help AIS patients be successful post-discharge. SCL Health will implement monthly review of performance on these core measures and create a standardized follow-up protocol to address fallouts across the SCL Health System and Hospitals. Standardizing these processes will create efficiencies across the system and identify opportunities in patient care that are vital to optimizing patient outcomes.

TARGET POPULATION

The target population for this measure work would be Medicaid patients that present with ischemic stroke and are discharged with statin medications. In order to raise the medication compliance for



the Medicaid population, it will be important to unpack why the Medicaid population sits below the system average and to address any barriers that can be determined. This work will get done throughout the Implementation years of HTP. Potential barriers to medication compliance may include factors related to social determinants of health, such as access to a pharmacy or ability to pay for medications. A high percentage of adults in the Good Samaritan Medical Center service area are considered overweight or obese, and/or diagnosed with hypertension. The data shows these individuals are more likely to utilize the ED at higher rates than other populations. Individuals with cardiovascular disease are also of particular concern.

CONNECTION BETWEEN INTERVENTION & HTP GOALS

This work is especially important to health equity initiatives that give effort to reducing poorer healthcare outcomes associated with populations living below the Federal Poverty level and especially those that are not able to work due to a disabling diagnosis. A patient's economic status should not determine their health outcomes. This measure intervention is a step towards creating better health equity in our communities.

Along with the potential to increase healthy outcomes when patients are discharged with statin medications, this intervention has the potential to lower the Medicaid spend on disability claims by reducing potential for disability caused by recurrence of stroke. When Ischemic Stroke patients are prescribed statin medication and are compliant, it will greatly reduce their potential for disabilities.

For these reasons, this measure meets the exact intentions of the Hospital Transformation Program - to increase healthy outcomes and to lower costs. Long-term care expenses that can be caused by disabilities is of high cost to the Medicaid program. Reducing the incidence of short term, long term, and chronic disabilities would help to reduce the spend in this area and improve the quality of life for patients.

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 Community Engagement process showed us that social determinants of health are a big factor in the lives of Medicaid patients. Social determinants lead to adverse health effects and worsen medical conditions when left unattended. Stress due to struggling economic situations and access to unhealthy food lead to high blood pressure and cholesterol build up. Patients who experience these conditions are at higher risk for ischemic stroke. Acute ischemic stroke is one of the fastest growing



diagnoses in the country requiring an inpatient hospital admission (Sg2, 2020) and is the number one cause of disability in the United States and a large portion of the post acute care cost in this country (Grundy, 2018). Stroke death rates (age-adjusted per 100,000) and ranking are among the top ten causes of death in 6 counties in the Good Samaritan Medical Center service area.

According to CHNE findings, a significant percentage of metro Denver area adults are considered overweight or obese, and/or have been diagnosed with hypertension. Good Samaritan Medical Center's most recent CNHA also identified cardiovascular disease as a significant community health need and priority area of focus on the CHIP. This measure aligns with the hospital's goals as outlined in the CHIP regarding support for stroke survivors and caregivers, including increased knowledge of cardiovascular disease in the community, providing support for caregivers and stroke survivors, and improving workforce capacity and competence to provide the best care possible for cardiac event and stroke patients.

Leveraging the patient engagement tool, Cipher, as a medical resource will enable the Stroke Coordinators to reach more patients for follow-up after discharge. SCL Health will evaluate the potential of a Navigator program to work alongside the Stroke Coordinators to engage with patients as they discharge from the hospital and have transitions of care needs. For example, identifying barriers to care, such as challenges in filling statin medication prescriptions for the homeless population and the inability to reach homeless patients for medication compliance conversations post-discharge. Diving into the high cost and utilization episodes that interact with stroke, such as hyperlipidemia, could be included in the process of addressing Potentially Avoidable Complications in the Hospital Index measure. Through the implementation years of HTP the identification of multi-measure alignment and the creation of efficiencies will be addressed for this measure.

Additionally, several strong community partnerships have been established through the CHIP efforts, which will also align with the goals of this measure as it relates to HTP. Key community stakeholders include: 9 Health Fair, Arvada Fire Dept., Aspen Ridge Elementary School, American Heart and Stroke Association, Blue Sky Neurology, Boulder Community Health, Boulder Neurosurgical and Spine Association, Centura Health, Frederick and Firestone Fire Dept., HCA Healthcare, Lafayette Fire Dept., Metro North Fire Dept., Local Community Festivals (Erie, Lafayette, Louisville, Broomfield, Westminster, Mountain View Fire Dept., Regional Stroke and Cardiac Rehabilitation Facilities, Retreat and refresh Stroke camp, Rocky Mountain Stroke Association, SCL Health Heart and Vascular Institute, Regional Stroke support groups, Thornton Fire Dept., Thornton Police Dept., United Stroke Alliance, UC Health System, Westminster Fire Dept., and WOW! Children's Museum. Additional community partners will be engaged as appropriate throughout the HTP process.

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)

SUMMARY OF RESEARCH & EVIDENCE BASED PRACTICES

The Stroke work at SCL Health is informed by a best practice evidence base through The Joint Commission and Get with The Guidelines, the national association for stroke work in the clinical setting. SCL Health receives accreditation and certification based on best practices expectations as identified by The Joint Commission. The Joint Commission gathers their best practice evidence through scientific literature, expert consensus, and is reviewed by The Board of Commissioners. The Joint Commission engages with medical providers, healthcare professionals, subject matter experts, consumers, and government agencies. The evidence based best practices for this measure are aligned and certified by The Joint Commission.

The Joint Commission (2018) Stroke.

<https://www.jointcommission.org/measurement/measures/stroke/>

[Get With The Guidelines® - Stroke | American Heart Association](#)

Grundy, S.M, et al. (2018). AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Circulation, Volume 139, Issue 25, 18 June 2019, Pages e1082-e1143 <https://doi.org/10.1161/CIR.0000000000000625>

Additionally, best practices evidence can be seen by such peer reviewed medical studies which inform healthcare organizations that influence the healthcare community such as the American Heart Association:

Powers, W.J., Rabinstein, A.A., Ackerson, T. (2019), Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association. Stroke. 2019;20:e344-s418.

<https://doi.org/10.1161/STR.0000000000000211>

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)

There are no identified direct measure initiative alignment at this time. The best alignment would be with the ACC initiatives to identify patients with high healthcare costs and address their health needs. This includes providing support for patients who cannot get connected to the right resources or care options, reducing Emergency Department utilization, and reducing readmissions.

Patients discharged with statin medication is a secondary prevention tactic that should significantly reduce the chances of readmission, which is a healthcare cost driver. Readmission is often an indication that the patient is not connected to the appropriate level of care or does not understand how to manage their care after discharge. The SCL Health Stroke Coordinators outreach to the patients to ensure they know how to use their statin medications and answer any questions they might have. This work aims to reduce readmissions, reduce cost, and improve patients health outcomes.

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 intervention is one that the SCL Health facilities have significant experience with. The stroke programs at each of the sites are well established and have been utilizing Lean performance



improvement methodology to improve compliance to the core measures and patient outcomes for several years. In 2017, the stroke coordinators at the Colorado sites began meeting regularly to discuss issues and identify opportunities for collaborating as a system to resolve them. Examples of this work are defining neuro checks, re-organizing order sets in the ED and standardizing imagining in the AIS patient. Consistent with the CHNA, stroke coordinators at Good Samaritan Center maintain Stroke Center certification and work to increase staff and community knowledge by organizing educational activities.

Stroke Education throughout the system has also been standardized so each of the patients receive the same education. Furthermore, a SCL Health Colorado Stroke Dashboard was created in 2018 and is reviewed by the system stroke coordinators as well as the SCL Health Colorado Neuroscience Council on a monthly basis. Time to treatment for AIS patients is the majority of what is included on this dashboard and this level of monitoring has significantly improved times across the system. Compliance to STK-6 - Statin prescribed at discharge can be easily added to this dashboard for system review and will no doubt achieve the same performance improvements results.

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 stated above, the program will treat patients to reduce disabilities that could be caused, at no fault to the patient, by means of the barriers that are associated with a lower economic status. Looking at SCL Health data for Medicaid Stroke patients, this falls under the SCL Health Standard of 91%. The Medicaid Population shows 88% that are discharged on a Statin Medication. During HTP, we plan to bring the Medicaid Population up to 91% for SCL Health. This measure will impact one of the highest cost and utilization conditions in SCL Health Medicaid data - hyperlipidemia.

The work that will be done to improve upon the process already in place will be to add a tracking indicator to the Stroke dashboard for prescribing Statin Medication to track the success of this measure within stroke specifically. The data will be reviewed and monitored across all SCL Health hospitals through the Stroke Coordinators. SCL Health will use the Stroke Coordinator meetings to review Statin Medication prescribing and patient medication compliance. In this review, the Coordinators will identify gaps, share best practice, and identify opportunities. The data review will allow for performance improvement activities to ensure the prescribing rate at peak performance.



- 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](#).

II. Overview of Intervention

1. Name of Intervention: Maternal Mental Health Collaborative
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. CP6

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)

PROPOSED INTERVENTIONS & DESCRIPTION

Maternal Mental Health Collaborative

Focus Area - Core Populations
CP6: Screening and Referral for Perinatal and Postpartum Depression and Anxiety and Notification of Positive Screens to the RAE



When perinatal mood and anxiety disorders go undetected, undiagnosed and untreated, mothers and their infants suffer adverse effects with long-term consequences.

The SCL Health Maternal Mental Health Project Advisory Committee, working with HTP Core Teams and the HTP Care Site Steering Committees, will lead the development and implementation of the Perinatal Collaborative Action Plan, which will meet the following objectives:

- 1.) Implement a system-wide initiative to ensure that patients have access to integrated behavioral health services, in addition to existing maternal health services, focusing on the most critical aspects of evidence-based patient care, including: a) access to prevention and treatment interventions; b) patient-education materials; c) coordinated care plans with integrated behavioral health services; d) access to providers and support specialists using technology, including telemedicine options; and e) referrals to RAEs, community resources and community-based organizations that can provide additional support.
- 2.) Utilize evidence-based strategies to ensure that perinatal patients are empowered to be actively involved in the development of their care plans, including access to universal screening and education, information about challenges related to postpartum emotional adjustment, and treatment for perinatal mood and anxiety disorders.
- 3.) Educate maternal health patient-care providers, case managers, and clinicians to meet core competency requirements, as well as ensuring access to evidence-based training/continuing education opportunities related to the rapidly advancing perinatal behavioral health treatment options.
- 4.) Develop and implement a plan that will operationalize evidence-based screening tools and procedures, such as a) universal behavioral health assessments; b) streamlined RAE referral procedures for women actively suffering from perinatal mood and anxiety disorders or whose screening identifies them at-risk for developing a perinatal mood or anxiety disorder.
- 5.) Refine and adjust workflows to initiate a stage-based response protocol for positive mental health screens that include further behavioral health evaluation, appropriately timed behavioral health interventions and emergency response protocols. Workflow designs will emphasize management of patient shifts between inpatient and outpatient care settings to ensure that well-established referral pathways with RAEs, community partners and affiliated caregivers are in place to use as-needed, and without causing unnecessary delays or barriers to treatment or care.
6. Maximize existing technology, including EHR, to embed screening results and other assessment tools as part of the electronic medical record, to increase the likelihood of a patient receiving effective postpartum follow-up care that takes into consideration of a patient's risk factors during follow-up visits with physicians, lactation specialists, pelvic floor treatment specialists, and behavioral health providers.
- 7.) Establish continuous learning practices aimed at strengthening communication between patients, care teams, payers, and RAEs, ensuring that benefit-related processes and procedures do not create a delay or barrier to evidence-based, medically necessary care. These learning practices can also support multidisciplinary review of adverse mental health outcomes and safety.



8.) Evaluate and implement evolving telehealth options for behavioral health assessment and intervention in an effort to reduce the barriers that patients experience when trying to access behavioral health care.

TARGET POPULATION

The target population for this measure will be women seen in the hospital setting during their perinatal period. SCL Health repeatedly heard that maternal mental health and improving the healthcare outcomes for pregnant women is a priority for the community. Hospital data for Good Samaritan Medical Center identified pregnant women as being high utilizers of the Emergency Department. Screenings will target pregnant women and mothers with existing behavioral health needs (especially those with a child with a developmental disability). Pregnant women who lack prenatal care were also identified as populations of focus for Good Samaritan Medical Center, as well as homeless women, refugees, immigrants and women with low literacy.

CONNECTION BETWEEN INTERVENTION & HTP GOALS

SCL Health's mission-driven work calls on us to help improve the health and wellbeing of women and their families by identifying and treating perinatal mood and anxiety disorders as early as possible. HTP Local Measures specifically identify screening and referral processes relative to postpartum depression and anxiety (referred to as perinatal mood and anxiety disorder in interventions). A three-year pilot between SCL Health/Saint Joseph Hospital and the Zoma Foundation has helped to develop the foundational work on which these system-wide interventions are based. This HTP Local Measure intervention provides an ongoing framework that will allow SCL to take a care site-focused pilot program to system-wide implementation.

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 most recent Community Health Needs Assessment (CHNA) issued in 2018 indicated that mental health, economic stability, and food security represented the greatest opportunities to improve the health of the community. In terms of maternal mental health, as many as one out of every five Denver women experience pregnancy-related depression. Maternal/perinatal depression was frequently identified in the CHNE as compromising maternal health and birth outcomes. Nearly one in 10 (8.9 percent) of women in the metro Denver area report perinatal depression symptoms after their new baby was born. Similarly, 68.9 percent of women experience one or more major life stress events in the 12 months prior to their delivery. The rate of maternal mortality (death during



pregnancy or within 1 year postpartum) nearly doubled in Colorado between 2008 and 2013. Data suggests that 30 percent of deaths (63 women) were due to “self-harm” - drug overdose or suicide.

Medicaid members, according to several studies, have higher rates of postpartum depression than other income groups (Johnson et al. 2018). Additionally, health equity reports consistently point to disparities in maternal mortality rates for women of color, who are still four times more likely than white women to die in childbirth. Women with existing behavioral health needs (especially those with a child with a developmental disability), homeless women, refugees, immigrants and women with low literacy are also at greater risk.

Community engagement efforts identify gaps in behavioral health services, in general, as a critical need. Community partners told us that there is a general lack of behavioral health services and a lack of reliable referral pathways to services. Perinatal depression screenings and referral will help to coordinate that care across the pregnancy and create continuity for the patient, informed providers, and access to needed care. Postpartum depression screening will target pregnant women and baby care (Mom/Baby), mothers with behavioral health needs – especially when mothers have newborns or children with an intellectual and/or developmental disability – or have significant care and social support needs. These individuals need supportive or sober housing that is family-friendly. They also need care providers who can treat the whole family – both parent and child – in an integrated setting.

Untreated perinatal mood and anxiety disorders are associated with: low birth weight, preterm birth, early weaning, negative developmental consequences for mother and child, an increased risk of partnership dissolution, an increased risk of depression and anxiety in non-birth partners, and economic loss. This work aims to prevent these consequences by detecting and treating maternal mental health disorders as soon as possible.

SCL Health plans to leverage resources, such as those offered by the RAEs, to connect pregnant women to their healthcare benefits and behavioral health network when this is not already established. During the Hospital Transformation Program years, each SCL Health Hospital will work with their RAE to identify and align opportunities for engagement and improvement. Referring back to the delivering physician will be a key factor in successfully fulfilling this measure. Partners include Clinica, Women’s Health Group, and Superior OBGYN. Other partners will be engaged as needed.

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)

SUMMARY OF RESEARCH & EVIDENCE-BASED PRACTICES

[Consensus Bundle on Maternal Mental Health](#)

SCL Health has used the Consensus Bundle on Maternal Mental Health as a guiding document in program and intervention development.

Abstract: In 2015, the Council on Patient Safety in Women's Health Care convened an interdisciplinary workgroup to develop an **evidence-based patient safety bundle to address maternal mental health**. The focus of this bundle is perinatal mood and anxiety disorders. The bundle is modeled after other bundles released by the Council on Patient Safety in Women's Health Care and provides broad direction for incorporating perinatal mood and anxiety disorder screening, intervention, referral, and follow-up into maternity care practice across health care settings. This commentary provides information to assist with bundle implementation.

Kendig, S., Keats, J. P., Hoffman, M. C., Kay, L. B., Miller, E. S., Moore Simas, T. A., Frieder, A., Hackley, B., Indman, P., Raines, C., Semenuk, K., Wisner, K. L., & Lemieux, L. A. (2017). Consensus Bundle on Maternal Mental Health: Perinatal Depression and Anxiety. *Obstetrics and gynecology*, 129(3), 422-430. <https://doi.org/10.1097/AOG.0000000000001902>

[Colorado's Maternal Mental Health Framework](#) SCL Health has relied on this framework created for all Coloradans to support effective collaboration, impactful action, and accelerated progress toward improved maternal mental health.

Maternal Mental Health Framework. The Colorado Maternal Mental Health Framework.

<https://coloradomaternalmentalhealth.org/wp-content/uploads/2018/12/The-Colorado-Maternal-Mental-Health-Framework-2.pdf>

[USPSTF Perinatal Depression: Preventive Interventions 2019](#)

SCL Health has relied on this publication to inform integrated behavioral health interventions. Additionally, recommendations made by USPSTF in regard to postpartum depression prevention interventions informed SCL Health's decision to participate in a Roses (Reach Out Stay Strong Essentials) sustainability study with Brown and Michigan State University.

The following peer reviewed randomized control trials provide clinical evidence for the Roses Curriculum which shows a reduction in postpartum depression by about 50% in women with multiple psycho-social risk factors.

1.) [Postpartum Depression in Women Receiving Public Assistance: Pilot Study of an interpersonal-therapy-oriented group intervention](#)

2.) [A Preventive Intervention for Pregnant Women on Public Assistance at Risk for Postpartum Depression](#)

3.) [Brief Report: A Preventative Intervention for Pregnant Women on Public Assistance at Risk for Postpartum Depression](#)

4.) [Randomized Controlled Trial to Prevent Postpartum Depression in Adolescent Mothers](#)



Perinatal Depression: Preventative Interventions (2019). U.S. Preventive Services Task Force. <https://uspreventiveservicestaskforce.org/uspstf/recommendation/perinatal-depression-preventive-interventions>

[Massachusetts Child Psychiatry Access Program For Moms](#)

SCL Health has used this best practice tool kit for guidance in regard to establishing Edinburgh Postnatal Depression Scale cut off scores used to develop score based response protocols in both the inpatient and outpatient settings.

Abstract: MCPAP for Moms expands the successful Massachusetts Child Psychiatry Access Program (MCPAP) model, which was created in 2004. MCPAP's purpose is to support primary care providers with identifying and managing their patients' mental health and substance use concerns in an environment in which child psychiatry is scarce. Similarly, MCPAP for Moms helps front-line providers identify and address the mental health and substance use concerns of their pregnant and postpartum patients.

Obstetric Provider Toolkit (2019). Massachusetts Child Psychiatry Access Program for Moms.

<https://www.mcpapformoms.org/Docs/AdultProviderToolkit12.09.2019.pdf>

[ACOG Committee Opinion No. 757: Screening for Perinatal Depression](#)

ACOG Committee Opinion No. 757: Screening for Perinatal Depression. *Obstet Gynecol.* 2018;132(5):e208-e212. doi:10.1097/AOG.0000000000002927

[American College of Nurse-Midwives Position Statement: Depression in Women 2013](#)

Depression in Women (2013). The American College of Nurse-Midwives.

<http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000061/Depression%20in%20Women%20May%202013.pdf>

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: See write-up below (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)

The interventions outlined in this work are aligned with the Colorado Maternal Mental Health Collaborative and Framework and the Child Health State Action Plan. Depression screening and RAE notification in the acute setting continues to align with the work of Accountable Care Organizations the RAEs to implement key point indicators (KPIs) to drive improvements in maternal health. RAEs can serve as valuable partners to ensure that hospitals can be notified when admitting women for labor and delivery. If RAEs are able to alert hospital-based Labor & Delivery teams about high-risk pregnancies, including care they received from Maternal-Fetal Medicine specialists or perinatologists, our maternal health teams can be better prepared to serve the patient's needs.

There is significant overlap with the Hospital Quality Improvement Program (HQIP), which currently includes measures aimed at improving maternal health and perinatal work, including treatment of depression and anxiety.

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)

SCL Health has the opportunity to leverage the expertise, knowledge and experience of some of the best maternal care health teams in the country. For more than 150 years, SCL Health care sites have ensured women receive the care they need throughout the term of their pregnancy and provided the team-based support needed to support women through the first year postpartum. Saint Joseph Hospital, St. Mary's Medical Center and Lutheran Medical Center are all well-known throughout our communities for the outstanding care they provide to pregnant women, especially leading up to and during labor & delivery. All three of these facilities have been recognized nationally for the outstanding care provided by Labor & Delivery, Mom & Baby, and NICU teams. The HTP work will leverage the well established and deep routed knowledge in these three sites to develop and enhance the HTP intervention at all SCL Health sites.

Helping families have appointments for OBGYN & family medicine clinics prior to discharge will increase the likelihood that families will follow-up with their care. There is also opportunity for improvement around discharge transitions, such as "making a connection" for individuals, rather than simply providing a list of services. Another potential area of focus is improved complex care



management coordination and care transitions through increased communication with health care organizations and other partners (HIE, CORHIO, Care Everywhere, CCD).

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)

SCL Health has explored screening and intervention practices through a pilot program in several hospitals and clinics, however the work remains in early stages and must be expanded upon, standardized and implemented across the SCL Health system in order to have the intended impact for all of the women and families that SCL Health serves. The expanded focus of this work will include evaluation and modification of piloted work flows for screening and intervention, ongoing exploration of telehealth options, RAE engagement and patient connection, and implementing all aspects of the maternal health safety bundle work at all SCL Health hospitals.

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)
CCHA	Regional Accountable Entity	Yes	Coordinated referral process

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](#).

II. Overview of Intervention

1. Name of Intervention: Screening for Transitions of Care in Adults with Disabilities
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. CP4



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)

PROPOSED INTERVENTIONS & DESCRIPTION

Screening for Transitions of Care in Adults with Disabilities

Focus Area - Core Populations

CP4: Screening for Transitions of Care Supports in Adults with Disabilities

The Case Management Team, working closely with HTP Site Steering Committees and the HTP Core Team, will develop and implement an Adults with Disabilities Transitions of Care Action Plan that seeks to meet the following objectives:

- 1) Increase continuity of care and improve patient outcomes by implementing an action plan designed to ensure that hospital-based teams have access to information and assessments that are required to inform an effective, evidence-based Transition of Care plan for adults designated with disabilities.
- 2) Maximize technological resources, including EHRs, to ensure that screenings and assessments performed by hospital-based care teams, primary care physicians, long-term care or skilled-nursing facilities, or home-based services, such as OT/PT/RT, are documented and accessible to health care providers involved in patient’s coordinated care plans.



- 3) Identify best practices and evidence-based strategies to ensure that hospital-based assessments and screenings also include participation and feedback provided by designated patient representatives, family members, and other patient-identified caregivers, including procedures, to ensure that feedback is documented in the patient's EHR.
- 4) Determine the feasibility of developing community partnerships in order to promote improved patient access to long-term services and support, allowing individuals to remain independent in the community.
- 5) Support evidence-based transitions of care by improving collection of data and health analytics, including metrics related to patient's mobility, cognition, Activities of Daily Living (ADLs), and other key metrics designed to determine the patient's functional status, including improved documentation related to observations and reports.

TARGET POPULATION

The target population for this measure intervention work will be Medicaid patients with a disability. The work will entail identifying patients with disabilities and ensuring there are transitions of care support services. There will be an interest in diving into data during HTP Implementation years to analyze any subset in this population that might potentially have more barriers to care. The high percentage of adults with disabilities served by Good Samaritan Medical Center were identified as being especially at risk of physical and behavioral health needs and will be a population of focus. Individuals experiencing challenges related to SDOH, such as accessing reliable transportation, were also identified as a priority and may be a target population for this measure.

CONNECTION BETWEEN INTERVENTION & HTP GOALS

Accurate identification of the target population, robust functional assessments, and tailored interventions support the HTP goal of improving the performance of the delivery system by ensuring appropriate care in appropriate settings. This intervention supports the HTP goal of increased collaboration between hospitals and other providers.

4. Please use the space below to describe how the intervention and any selected local quality measures to be addressed by the intervention align with community needs identified throughout the Community and Health Neighborhood Engagement process (including data identified in the hospital's CHNE midpoint and final reports), including but not limited to:
 - How the intervention and any selected local quality measures to be addressed by the intervention were selected based on identified community needs, including how they align with identified significant behavioral and physical health needs and / or service capacity resources and gaps, including related to care transitions and social determinants of health;
 - How the population of focus aligns with identified community needs; and
 - How the proposed intervention will leverage available medical and / or social resources and partners.

Response (Please seek to limit the response to 1,500 words or less)

According to CHNE findings, Good Samaritan Medical Center serves a high percentage of adults with disabilities. Individuals with intellectual disabilities or developmental disabilities were identified as



being especially at risk of physical and behavioral health needs. This population was identified as having limited access to even “basic” services such as mammograms and having accurate heights/weights measured, in addition to specialty care and other services. These gaps in access to care are driven by limited provider training and competencies in serving these populations but can also be due to equipment that cannot accommodate individuals with wheelchairs, for example. There are also limited treatment options for these individuals outside a hospital setting, especially if the individual is unable to go back to a provider due to ‘non-compliance’ with previous care.

Improvements in care transitions and sharing of information was cited by several of the RAEs and adults with disabilities are a vulnerable population with unique SDOH needs. Many of the community health departments we regularly partner with also expressed interest in improving our ability to connect vulnerable populations with available county programs. Through the CHNE process, adults with disabilities were identified as an underserved population that experiences greater barriers to care. SCL Health believes it is important to evaluate and support their needs better so that transitions of care are more effective and consistent. Poor transitions of care can result in readmissions or longer lengths of stay. Given this correlation, this intervention impacts multiple measures. This measure also affords us the opportunity to improve RAE relationships through better TOC data exchange and establishing RAE JOCs to address specific issues. By digitizing and automating our assessment tool, we will be able to share more information faster with all partners (RAEs, Health Departments, and other community resources) and facilitate better handoffs with organizations who are best suited to address the needs of disabled adults. This measure also aligns with Joint Commission Conditions of Participation requirements. As such, existing Case Management, Quality, and Performance Improvement staff will be available to participate in the planning and implementation of this measure while ensuring alignment with COPs.

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)

Evidence based on best practices, emerging practices, and randomized control trials show that transitions of care support improves a patient’s access to post-acute care, increases their success of a healthy recovery, and decreases risk of readmission. Patients might readmit to the hospital when they are unable to find the most appropriate care after hospital discharge and sometimes conditions reach crisis level or acute levels again. Clinically, this position is undesirable as hospitals and patients both want successful recovery. The references below show that when providing transitions



of care support, successful recovery is more likely and the rate of readmissions go down. In order for SCL Hospitals to implement transitions of care support, a screening tool will be built out as part of this measure intervention to identify those patients in need of transitions of care support.

REFERENCES:

Braet A, Weltens C, Sermeus W. Effectiveness of discharge interventions from hospital to home on hospital readmissions: a systematic review. JBI Database System Rev Implement Rep. 2016 Feb;14(2):106-73. doi: 10.11124/jbisrir-2016-2381. PMID: 27536797.

National Academies of Sciences, Engineering, and Medicine. 2019. Functional Assessment for Adults with Disabilities. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25376>

<https://www.aota.org/About-Occupational-Therapy/Professionals/WI/Capacity-Eval.aspx>

[Improving Care Transitions | Medicaid](#)

[Evidence-Based Care Transitions Program | ACL Administration for Community Living](#)

[Creating Better Systems of Care for Adults with Disabilities | Commonwealth Fund](#)

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)

The work of performing an screening and assessment of transitions of care support needs for patients aligns and compliments with ACC work under the RAEs. The RAEs function as an avenue for care coordination for Medicaid patients and care coordination is important for transitions of care supports.

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)

As mentioned, completion of a functional assessment of adults with disabilities has always been a standard aspect of a nurse Case Managers role, but assessments were not standardized and there was variation in processes.

SCL Health leveraged its internal experts (Nursing, Case Manage, Quality, Performance Improvements) to develop a new standardized template. As SCL Health works with RAEs, Health Departments and other community resources to develop and implement a plan for sharing assessment information and improving transitions of care, it remains flexible in its template development. SCL Health will collect feedback from all stakeholders and incorporate feedback into its processes and forms. Increased advance directive discussions with a health care provider and access/referrals to Hospice earlier in the care process are opportunities for improvement.

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)

Yes this is an existing intervention. Through the HTP program, several improvements will be pursued, as previously outlined in the intervention. As this type of functional assessment is a Condition of Participation (COP), it is ideal for this measure. Standardizing the assessment, loading it into a



digital template and sharing it electronically with partners provides numerous opportunities for care improvements. The value-add of developing tighter RAE relationships and creating a formal structure for discussing transitions of care, will improve handoffs and, consequently, the health outcomes of adults with disabilities. Connecting these adults with community resources in a more timely and streamlined way will also improve their outcomes.

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](#).

II. Overview of Intervention

1. Name of Intervention: Telehealth Implementation and Expansion

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



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. COE2

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)

PROPOSED INTERVENTION AND DESCRIPTION

Telehealth Implementation and Expansion



Focus Area - Clinical and Operational Efficiencies COE2: Implementation/Expansion of Telemedicine Visits

The implementation and expansion of telemedicine throughout SCL Health hospitals is an ideal match for the Hospital Transformation Program (HTP) and comes at the most opportune time. In surveying SCL Health hospitals and community partners during the COVID pandemic, it has been made clear that the temporary expansion of telemedicine benefits made a positive impact on patients and services and, therefore, its continued and expanded use is warranted.

We have seen increased patient engagement as access to care barriers have been removed through telemedicine technologies. Less PPE is needed for patient engagement and potential exposure to disease through human to human contact is minimized through telemedicine options. Moving forward, SCL Health identified opportunities through telemedicine to improve clinical workflows and engage in collaboration as technology platforms make virtual healthcare options more accessible to patients.

Additionally, telemedicine is a way to reduce cost and plug gaps in care, either for providers or patients, which results in greater efficiencies. For the implementation and expansion of telemedicine, SCL Health will leverage System resources and support through the Virtual Health Department and work with each Hospital to identify gaps in care and identify where technology could create efficiencies in work and patient flows. The initial process will entail the following work steps:

- 1.) Hospital and System engagement: This work will entail the identification of appropriate internal stakeholders and partners. The oversight will be led by SCL Health's Virtual Health Department and each SCL Health Colorado Hospital. Cross-functional teams will be created to include the Chief Medical Officers, Chief Operating Officers, Chief Nursing Officers, Service Line Directors, Nurse leaders, operational leaders, and any determined partners.
- 2.) Gap analysis: Once the stakeholders are at the table, there will be an evaluation of gaps in workflow and access, including geographic and/or gaps based on population, and identification of costly or inefficient processes. To follow, there will be an evaluation of telemedicine tools to match up the identified gaps or needs with the most appropriate technological solution. The evaluation process will take into consideration the overarching themes of the HTP program and SCL Health's approach to improve the patient experience, patient outcomes, and the evaluation of populations that would benefit from telemedicine technologies. Other topics discussed with community partners throughout the Community Health Neighborhood Engagement process will be included into the conversations, such as transitions of care supports, improved provider to provider communication across the care delivery system, and increased access to specialty care.
- 3.) Implementation plan and execution: SCL Health hospitals will work with System support departments, such as the System's Enterprise Program Management Office for large projects, and other departments that can be utilized to accomplish an implementation plan for identified opportunities. The plan will entail an evaluation of the scope of work to determine the resources needed and Project Management options to engage. Efforts that ensure that telemedicine meets the same standards of care as in person care, such as equipment, technology, compliance review, coding/billing, documentation and credentialing and privileging processes, will be evaluated to ensure appropriate engagement. The next step is training and education, which are critical success factors. Education includes making sure that the most current billing and coding process information is shared and updates are transmitted in a timely manner. Tips sheets will be provided and on-site training will be conducted so that each associate knows their established role, which is defined to



meet process and regulatory requirements. Finally, training staff to set up the appropriate technology for patient interactions so that the process does not detract from or delay the patient and provider experience. The SCL Health goal of implementing telemedicine technologies is to get the right devices, in the right room, at the right time.

4.) Data and feedback-a data and feedback loop will be created to track plan progress which will include measuring, not only patient access and healthcare outcomes, but cost and financial stewardship in programs such as Medicaid. The work entails measuring patient satisfaction through Press Ganey and tracking volume per payor source such as with Medicaid. Effectiveness and patient satisfaction outcomes will be built into a feedback loop for any implementation and expansion of telemedicine interventions.

TARGET POPULATION

The target population for the work under this measure intervention will be determined through the Implementation years of the HTP. During the Implementation years there will be an analysis that will determine where the greatest need is for telemedicine implementation and expansion. Current areas of opportunity at Good Samaritan Medical Center include incorporating telemedicine services in behavioral health in the Emergency Department and Endocrinology. Good Samaritan Medical Center will look at all opportunities with consideration of the remote options that have been expanded under the COVID emergency. It has been discovered that some lines of service have had more engagement and fewer barriers to care due to remote options. All of this work that has happened over the past year to accommodate remote access to services will be analyzed for feasibility of long term roll-out and permanent implementation. This measure will focus on perinatal patients and individuals facing barriers to care such as transportation.

CONNECTION BETWEEN INTERVENTION & HTP GOALS

SCL Health chose this intervention because it provides a catalyst to expand telemedicine in a more robust way that leverages System coordination and efficiencies of scale. Historically, telemedicine initiatives within SCL Health have been discrete programs or need driven projects, which has led to different levels of telemedicine capability and awareness across the System. Some hospitals utilize the technology in very basic ways, while others have applied it in more creative and dynamic ways. SCL Health Hospitals located in more rural areas have tended to capitalize on telemedicine more so than hospitals in urban areas.

HTP provides the platform for ‘raising all ships’ through expansion, sharing of telemedicine use cases and best practice, and investment in resources and technology so more patients can benefit from its use. Telemedicine will help SCL Health leverage technology to bring more care options to more patient groups in the future, and facilitate connection with patients and providers in a more efficient and streamlined way.

Creating more care options as the Medicaid population grows is extremely important. As the number of patients seeking care outpaces the availability of providers, telemedicine can help alleviate the demand and, when coupled with other interventions or strategies like risk stratification, it can be an optimal care path for low-risk and healthy patients, which leaves much needed face-to-face appointments slots for high-risk and the chronically ill patients. In the event of subsequent COVID-19 waves or other emergencies that make in-person physician visits unsafe, expanded telemedicine will be necessary.



Lastly, telemedicine provides a lower cost option to more costly methods of connecting patients and physicians in remote areas.

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)

SCL Health has received an overwhelmingly good patient satisfaction rating on telemedicine options. Telemedicine has been ranked 4.8 out of 5 on a recent patient survey and 97% of patients said they would schedule another telemedicine visit. During the current COVID-19 Pandemic, we have seen more patients attending their outpatient behavioral health appointments than previously reported, when transportation barriers prevented them from attending regularly. More perinatal patients have been engaged with behavioral health assessments during COVID-19 through telemedicine platforms. We have generally seen that patients like the inclusion of technology into their care. SCL Health would like to keep this wheel in motion and permanently develop and place telemedicine options for patients into the day-to-day services provided by SCL Health hospitals.

The Community needs learned through the Community Health Neighborhood Engagement process highlighted the fact that services lacked access for patients and that connections to behavioral health services were limited. Many community partners observed that the HTP priority populations frequently experience challenges accessing appropriate care to address their health needs. This may be influenced by multiple social barriers, such as population health and social supports (i.e., housing, food, transportation), as well as a lack of a centralized or aligned system to coordinate care and referrals. Incorporating telemedicine will be an important care intervention and cost-effective strategy at Good Samaritan Medical Center for addressing the access gap, particularly for those who are unable to physically visit their provider due to inadequate transportation, etc. Interpretation services for patients utilizing telemedicine services is also a need identified in the CHNE for metro Denver residents. The Hospital Transformation Program's Implementation years will give an opportunity for an analysis needed to identify gaps, such as those in the behavioral health system.

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)

SUMMARY OF RESEARCH & EVIDENCE-BASED PRACTICE

The evidence for this measure work has been through emerging practices as seen through the last year of the necessity of virtual health services due to the global pandemic. Consumer and provider preferences are also shifting toward a more favorable view of virtual health services as stated in the references below. Additionally a study by the Center of Improvement Value in Health Care (CIVHC) has shown that Medicaid patients have benefited greatly from virtual health access and their utilization outweighs that of any other patient by payer group. The study also shows improved access and utilization for behavioral health services which is a target for the Medicaid population under HTP.

Lastly, The Health Resource and Service Administration encourages the use of telehealth technologies to improve access and serve vulnerable populations, such as those living in rural communities or those living below the Federal Poverty Level.

REFERENCES:

Telehealth Programs (2020). Health Resource and Service Administration.
<https://www.hrsa.gov/rural-health/telehealth>

Other sources such as the Institute of Medicine state that using telemedicine in the hospital can reduce the length of stay, cost-reduction, and improve patient outcomes.

Board on Health Care Services; Institute of Medicine. The Role of Telehealth in an Evolving Health Care Environment: Workshop Summary. Washington (DC): National Academies Press (US); 2012 Nov 20. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK207145/>

[The Evidence Base for Telehealth: Reassurance in the Face of Rapid Expansion During the COVID-19 Pandemic | Effective Health Care Program \(ahrq.gov\)](#)

McKinsey & Company, Article: “ Telehealth: A quarter-trillion-dollar post-COVID-19 Reality?” May 2020

[Telehealth Services Analysis - CIVHC.org](#)

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)

Telemedicine implementation and expansion has alignment with creating cost efficiencies and alternative options to process and care. For these reasons, it aligns with any initiative that aims to increase access to care, provide incentive options to address barriers to care, such as lack of transportation, and encourage financial stewardship with public programs. Particularly this measure intervention could align with the Behavioral Health Task Force in creating care options if SCL Health is able to expand behavioral health consults for mental illness and substance use disorder treatment via telemedicine. This work will be evaluated during HTP Implementation years, since community feedback detailed the need for more access and coordination for these services.

The measure initiative aligns with the State work to parallel with neighboring states such as Nevada, Oregon, and Washington to address telehealth issues and share best practices regionally to improve services. The rollout of telehealth initiatives at SCL Health hospitals will give the State good data to add to regional discussions on how it will or can work in the acute hospital setting. We would be



eager to engage with the State to share information, such as pain points and best practices, as we roll out this measure initiative.

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)

The Virtual Health team at SCL Health has extensive experience in deploying and supporting telemedicine at SCL Health care sites in Montana and Colorado, however, up until recently, the use of telemedicine had been limited due to payer regulations and a limited ability to expand. The regulatory environment has prohibited the exploration and expansion of telemedicine options, since payer coverage has historically been limited to rural MSAs and certain types of services. As such, SCL Health confined its telemedicine footprint to the rural market until restrictions were lifted; additional expansion is necessary to meet patient needs and demand for this service.

The SCL Health Virtual Health team would provide guidance and multidisciplinary collaboration with SCL Health Colorado hospitals during the implementation of this measure initiative. The SCL Health Virtual Health team consists of the Vice President and Chief Innovations Officer, Virtual Health Directors, and Virtual Health Program Administrators. SCL Health has the supportive technology implemented in Epic, such as appropriate documentation, coding, and billing procedures, ready to deploy. Areas where telemedicine would be especially feasible at Good Samaritan Medical Center are in Endocrinology and within behavioral health in the ED.

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, while SCL Health has experience in this intervention and has been capitalizing on telemedicine solutions where the regulatory environment permits, telemedicine work at SCL Health Colorado sites is not yet a robust program. HTP affords SCL Health the opportunity during the implementation years to systematically develop telemedicine options and grow care delivery with technology. Telemedicine also affords us the opportunity to develop creative solutions for HTP instead of confining ourselves to ‘brick-and-mortar’ options.



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](#).





Broomfield-Payer Contracting and Strategy

Colorado Department of Health Care Policy and Financing
303 E. 17th Ave.
Denver, CO 80203
RE: HTP Measure Partnerships

To State Administrators,

SCL Health will engage with Colorado Community Health Alliance (CCHA) as part of the RAE and Hospital collaborative activities necessary for the Hospital Transformation Program administered by the Colorado Department of Health Care Policy and Financing. The contents of this letter will outline the extent of the collaborative work between Colorado Community Health Alliance and two SCL Health hospitals - Lutheran Medical Center and Good Samaritan Medical Center.

SCL Health has identified three measures and interventions that require a collaborative approach with CCHA:

- SW-CP1-Social Determinants of Health Screening and positive results referred to the RAE where appropriate.
• SW-BH1-Development of a coordinated discharge process for patients that have a diagnosis of a mental illness or substance use disorder.
• CP6-peri-natal depression screening and a RAE referral for patients that screen positive.

The collaboration entails CCHA and SCL Health to meet on a regular basis in order to understand current referral processes, identify needed referral documentation to ensure an actionable referral, identify successes and growth opportunities, as well as data exchange agreements. Of primary emphasis will be engagement to determine alignment between key performance areas that are important to each organization. The end product of these meetings is a coordinated and streamlined referral process that operates to serve the health care needs of shared populations enrolled in Health First Colorado, Colorado's Medicaid program.

The partners in this collaboration include:

SCL Health
Cindy Sears
Gaye Woods
Alison Keesler
David Nwangwu
Raylene Gomez
Katie Bovee

CCHA
Hanna Thomas
Laura Johnson
Krista Newton
Cara Herbert

Sincerely,

DocuSigned by:
Troy Holmes
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SCL Health
500 Eldorado Blvd. Building 4, Suite 4200
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Ken Nielsen
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