CHASE

Colorado Healthcare Affordability and Sustainability Enterprise

1570 Grant Street
Denver, CO 80203

Hospital Transformation Program

Intervention Proposal

I. Background Information

This Intervention Proposal is designed to clearly articulate the scope and goals of proposed transformation interventions aimed at impacting the hospital's selected local quality measures under the HTP. The following questions are meant to assist the state in identifying: the evidence base for each intervention; the need within targeted communities for the implementation of the interventions; and how the interventions will advance the goals of the HTP.

Hospitals will not be required to implement a specified number of interventions. Instead, participation requirements are based on the selection of local quality measures to impact within the five HTP Focus Areas:

- Reducing Avoidable Hospital Utilization
- Core Populations
- Behavioral Health and Substance Use Disorders
- Clinical and Operational Efficiencies
- Community Development Efforts to Address Population Health and Total Cost of Care

Hospitals will be required to address statewide measures for each Focus Area. Hospitals will also be required to select from the HTP list of local measures across the five Focus Areas based on community needs and the goals of the HTP. Each hospital will be required to work on a set of measures equal to 100 points. The number, mix and points per measure will vary according to hospital size, defined by bed count or specialty type:

- Large hospitals (91+ beds) will be accountable for six statewide measures, totaling 60 points and a minimum of four local measures, which will account for 40 points. Points per local measure will equal 40 divided by the number of local measures selected.
- Medium hospitals (26-90 beds) will be accountable for six statewide measures and a minimum of two local measures. If two local measures are selected, statewide measures will total 75 points, and local measures will account for 25 points. Points per local measure will equal 25 divided by the number of local measures selected. If three local measures are selected, then statewide measures will total 67 points and local measures will account for 33 points. Points per local measure will equal 33 divided by the number of local measures selected. If four or more local measures are selected, then statewide measures will then total 60 points and local measures will account for 40 points. Points per local measure will equal 40 divided by the number of local measures selected for four or more local measures.
- Small hospitals (<26 beds) excluding critical access hospitals will be accountable for six measures (statewide or local) to account for 100 points. Points per each measure will equal 100 divided by the number of measures selected.
- Critical access hospitals will be accountable for six measures (statewide or local) and will have their risk for measures reduced by 40%.
- Pediatric hospitals will be accountable for five statewide measures, totaling 50 points and a minimum of five local measures, which will account for 50 points. Points per local measure will equal 50 divided by the number of local measures selected.

- Respiratory specialty hospital(s) will be accountable for four statewide measures and a minimum of four local measures. If four measures are selected then statewide measures will total 56 points and local measures will account for 44 points. Points per local measure will equal 44 divided by the number of local measures selected. If five or more measures are selected, then statewide measures will total 50 points and local measures will total 50 points. Points per local measure will equal 50 divided by the number of local measures selected.

Hospitals have the option to work on local measures beyond the required minimum. This would spread the local measure risk by reducing the points per local measure.

In addition, hospitals have the option to replace a local measure with a statewide priority. Each statewide priority will be worth 20 points and if selected the points for each remaining local measure will be equal to the remaining total required local measure points divided by the number of local measures, greatly reducing the risk associated with those measures.

Hospitals should consult the Measure Scoring Summary, which can be found on the HTP webpage, for more information about measure selection, requirements and scoring.

Hospitals must then design five-year interventions that will impact their selected quality measures.

Hospitals must demonstrate that their proposed interventions will fulfill the goals of the HTP and are evidence-based. They must also justify the selection of each intervention based on the findings of the Community and Health Neighborhood Engagement process, including the environmental scan and feedback.

Each hospital will need to report its own data and submit its own application, but partnerships between hospitals may occur in some instances.

Hospitals may leverage existing resources for interventions, and existing interventions may be considered insofar as they expand or enhance the Department's noted goals and meet the following criteria:

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

In addition to meeting the above criteria, any hospital proposing existing interventions for participation in the HTP will be expected to propose and implement accelerated milestones in the Implementation Plan for such interventions.

This Intervention Proposal must be completed separately for each of the interventions being proposed for inclusion in the HTP. Hospitals must submit interventions that, together, address all of the statewide quality measures and the local quality measures listed in the hospital's response to Question 6 in the Hospital Application.

II. Overview of Intervention

1. Name of Intervention: Social Determinants Of Health Screen & Notification

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

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

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

Response (Please format the response as a numbered list)

1. SW-CP1 - Social Needs Screening and Notification

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

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

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

Health begins in our homes, schools, workplaces, neighborhoods, and communities. The conditions in which people are born, grow, live, work and age, and which are shaped by the distribution of money, power, and resources at global, national, and local levels. The five core domains encompass housing instability, food insecurity, transportation problems, utility help

needs, and interpersonal safety (7). SDOH impact several areas of population health, including medical factors influencing health (6). Boulder Community Health (BCH) is developing an organizationally consistent social determinant of health (SDOH) screening tool to identify Medicaid recipients, who are at risk of, or experiencing health disparities, and report to the Regional Accountable Entity (RAE). BCH will cultivate a robust screening tool through the EPIC Electronic Health Record (EHR). The BCH inpatient registered nurses (RNs) will complete the SDOH screening tool. A positive score will trigger a Case Management consult. The BCH Case Management team will utilize the referral platform to partner and communicate with community organizations electronically to provide appropriate and timely referrals. The Case Managers will work with the patient's interdisciplinary team and community partners to connect the patient to the most suitable resource based upon the five core domains. The intervention allows BCH to provide a supportive, value-based approach to advance health equity. We will also track data on how this intervention will give the individual patient connection to community resources, demonstrate community areas of inequity and need, segmentation of patient populations, and risk stratification.

4. Please use the space below to describe how the intervention and any selected local quality measures to be addressed by the intervention align with community needs identified throughout the Community and Health Neighborhood Engagement process (including data identified in the hospital's CHNE midpoint and final reports), including but not limited to:

- How the intervention and any selected local quality measures to be addressed by the intervention were selected based on identified community needs, including how they align with identified significant behavioral and physical health needs and / or service capacity resources and gaps, including related to care transitions and social determinants of health;
- How the population of focus aligns with identified community needs; and
- How the proposed intervention will leverage available medical and / or social resources and partners.

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

The CHNE process enabled BCH to understand the community needs and perceived gaps within the population served. BCH believes the intervention is invaluable, and the CHNE process allows us to decide on our measure and intervention selection. Based on results from the CHNE process and through our most recent Community Needs Assessment, BCH was able to identify the highest utilizers of care and start to align appropriate community support for the following patients: behavioral health, substance abuse, congestive heart failure and diabetic patients. Mental and or Behavioral health patients continue to be Boulder Community Hospital's highest utilizers of care, with congestive heart failure and diabetes being our third and fourth. Chronic conditions such as -chronic obstructive pulmonary disease, chronic pain management, coronary artery disease, diabetes palliative and Hospice care are some of our top chronic conditions that are also significant physical health conditions that attribute to our readmission rates. Many of our behavioral health patients have the above comorbid conditions that reflect poor access to care, neglect related to poor insight and lack of community resources. By addressing SW-CP1, Social Needs Screening and Notification, our organization can employ a supportive and proactive approach to getting patient needs met outside of the hospital setting.

BCH is well poised to address the aforementioned conditions both through relationships with our community partners as well as within BCH service lines. Namely, our primary care offices that

have a DEA X-Waivered provider on staff, to assist patients diagnosed with Opioid Use Disorder and/or pain management in the form of Suboxone therapy.

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)

Option 2 - Best practice supported by less than RCT evidence

While investigating SDOH is still an emerging practice across the healthcare continuum, a strong body of evidence exists to support this intervention. Increasing recognition that the U.S. healthcare system may not be the key driver of health outcomes indicates that a broader approach is needed (1). In fact, Braverman & Gottlieb (2014) tell us that medical care is responsible for a mere 10 - 15% of preventable mortality (2). Research shows that low socioeconomic status (SES) combined with a lack of social safety net, perpetuate systemic inequality in health (3). Since many Medicaid enrollees are categorized as low SES, there is correlation between this status and poorer health outcomes (4). This evidence clearly justifies a wholistic approach to addressing health outside of the healthcare system.

References -

1. Braveman, P., Egerter, S., Williams, D. (2011). The Social Determinants of Health: Coming of Age. Annual Review of Public Health, 32(1), 381-398

2. Artiga, S., &; Hinton, E. (2017). Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Retrieved March 19, 2021, from http://www.ccapcomcare.org/Newsletters/2018-05%20INSIGHT%20KFF%20Brief.pdf

3. Braveman, P. & Gottlieb, L. (2014) The Social Determinants of Health: It's Time to Consider the Causes of the Causes. Nursing in 3D: Diversity, Disparities, and Social Determinants. 129 (2) 19 -31. https://journals.sagepub.com/doi/pdf/10.1177/00333549141291S206

4. Case, K., Wegman, M., Herndon, J., Stoner, D. (2014). Health Risk Behaviors of Medicaid Recipients Diagnosed with Chronic Mental and Physical Illness. Retrieved March 19, 2021, from

https://www.researchgate.net/publication/266811744_Health_Risk_Behaviors_of_Medicaid_Recipients_Diagnosed_with_Chronic_Mental_and_Physical_Illness

5. Gostin, L.O. and Friedman, E.A. (2020), Health Inequalities. Hastings Center Report, 50: 6-8. https://doi.org/10.1002/hast.1108

6. Social Determinants of Health

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

7. Social determinants of health

https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

6. a. Does the focus of the proposed intervention intersect with ongoing initiatives statewide (including, but not limited to those included in the ACC, State Innovation Model and Comprehensive Primary Care Plus)?

☒ Yes

☐ No

b. If yes, please identity the applicable statewide initiative(s): (you may select more than one response from the list below)

☒ Behavioral Health Task Force

☐ Affordability Road Map

☐ IT Road Map

☐ HQIP

☐ ACC

☐ SIM Continuation

☐ Rx Tool

☐ Rural Support Fund

☒ SUD Waiver

☐ Health Care Workforce

☐ Jail Diversion

☐ Crisis Intervention

☐ Primary Care Payment Reform

☐ Other: ____ (please identify)

Please also use the space below to briefly explain how the hospital will ensure the intervention aligns with the applicable ongoing initiative(s).

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

The research provided above strongly supports BCH's engagement with measure SW CP1 - Social Needs Screening and Notification, and also perfectly aligns with the following HTP ongoing initiatives -

Behavioral Health Task Force - As nearly all of BCH's Medicaid enrollee patients experience some form of vulnerability, our staff can work in tandem with this HTP measure to address the statewide goal of a stronger, integrated, accessible and transparent behavioral healthcare system. By proactively exploring SDOH, with special focus on behavioral health, patients can be connected with services and resources to ensure access to the care necessary to meet their needs.

SUD Waiver - As stated previously, patients living with substance use disorders are some of the highest utilizers of BCH services. Outside of safe medical withdrawal management, and providing medical clearance for beginning treatment, the hospital is far from the appropriate setting for these participants. Currently the service of standalone medical detox does not exist within the Boulder community and the treatment programs that offer this service are not Medicaid providers. By engaging case management, to screen for SDOH that may precipitate or exacerbate substance use disorders, and incorporating the BCH PILLAR Program in discharge planning, fitting resources can not only be explored, but warm hand-offs can occur to assist in accessing care all along the continuum of substance abuse treatment and avoiding unnecessary medical visits.

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)

Nearly all substance abuse treatment organizations provide individual and group therapy, as well as case management and Medication Assisted Treatment (MAT). Some programming offers additional wrap around services such as guided meditation, acupuncture and various forms of financial assistance. By engaging in whole-person and client-centered care, successful treatment outcomes are far higher than modalities that focus solely on one area of concern.

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)

This intervention in this population is not already in existence; gathering focused information and data on the SDOH for our Medicaid population will be a new practice for BCH.

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)
BCH Ambulatory Clinics	Primary Care	Yes	DEA X-Waivered doctors and advanced practice providers providing Suboxone therapy in an outpatient setting.
Mental Health Partners	Community Behavioral Health	Yes?	Hx difficult to get pts connected…given that this is a Medicaid focused program….

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.