HOSPITAL TRANSFORMATION PROGRAM

COMMUNITY AND HEALTH NEIGHBORHOOD ENGAGEMENT

MIDPOINT REPORT

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# Instructions and Timeline

Via the Midpoint Report, program participants will report on Community and Health Neighborhood Engagement (CHNE) work over the first half of the pre-waiver process. Specifically, hospitals will use this report to update the State regarding efforts to engage community partners in completing an evidence-based environmental scan to identify community needs and resources and the hospital’s plans going forward.

The State will be reviewing Midpoint Reports to ensure:

* The process has been adequately inclusive of organizations that serve and represent the broad interests of the community and that no key stakeholders are excluded;
* A diverse and regular enough range of venues, locations, times and manners for engagement are being provided to allow for a meaningful opportunity for participation;
* Needed adjustments were made to the Action Plan and any divergence from the Action Plan is justified;
* The environmental scan assessment is complete, sufficiently detailed, and evidence-based, and was informed by community input; and
* Over the remainder of the pre-waiver CHNE process, community organizations will have meaningful opportunities to inform the hospital’s planning of its Hospital Transformation Program (HTP) participation.

Please note that the word limits included are guidelines. You may exceed them as necessary to fully respond to the question or information request.

Midpoint Reports must be submitted in .pdf form with all supporting documentation included in one document via e-mail by April 19, 2019 at 5pm to the Colorado HTP email address [COHTP@state.co.us](mailto:COHTP@state.co.us). Reports received after this deadline will not be considered.

Following the submission date, the State will review the reports. The reports will not be scored; however, the State will work collaboratively with participants to seek clarifications as needed and to ensure that there is agreement between the hospital and the State as to the plan for the remainder of the process, including plans to address any needed changes to the hospital’s CHNE process based on the review of the Midpoint Report.

# Contact Information

Please provide the legal name and Medicaid ID for the hospital for which this Midpoint Report is being submitted.

Hospital Name:

Hospital Medicaid ID Number:

Please provide any updates to the hospital address as well as to the names, titles, addresses and contact information for the hospital executive with signatory authority to whom official correspondence should be addressed and for the primary and secondary points of contact if that information has changed since submitting your CHNE Action Plan. If this information has not changed, this section can be left blank.

Hospital Address:

Hospital Executive Name:

Hospital Executive Title:

Hospital Executive Address:

Hospital Executive Phone number:

Hospital Executive Email Address:

Primary Contact Name:

Primary Contact Title:

Primary Contact Address:

Primary Contact Phone Number:

Primary Contact Email Address:

Secondary Contact Name:

Secondary Contact Title:

Secondary Contact Address:

Secondary Contact Phone Number:

Secondary Contact Email Address:

# Engagement Update

III.a. Please respond to the following questions to provide us with an update of the hospital’s engagement activities. Please note that the word limits are guidelines. You may exceed them as necessary to fully respond to the question or information request.

Please use the following grid to provide a list of external organizations that the hospital has engaged, including the organizational contact, the type of organization, and the organization-specific engagement activities undertaken with this organization. Please also note any specific connection of the organization to HTP priority populations and / or project topics.

| Organization Name | Organizational Contact | Organization Type | Engagement Activity | Connection to any specific HTP priority populations and / or project topics, as applicable |
| --- | --- | --- | --- | --- |
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|  |  |  |  |  |

Please use the following grid to provide a list of engagement activities, (e.g. workgroups, committees, meetings, discussion groups, public forums, etc.) that the hospital has undertaken, including the locations and manners for participation (e.g. in-person, by phone, in writing, etc; please also indicate if the participants facilitated or provided data analysis), frequency of the activity, the partners included, how notice was provided, and the key deliverables for each activity (e.g. action items, high-level decisions, documents drafted / finalized, data reports, etc).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Engagement Activity | Location and Manners for Participation | Frequency of Activity | Partners Included | How Activity Was Noticed | Key Deliverables |
|  |  |  |  |  |  |
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III.b. Please respond to the following questions to tell us about your experiences of executing your Action Plan, including the challenges you have faced and how, if at all, you have had to adjust in light of those challenges.

1. Please use the space below to describe:

* Any organizations that you expected to engage but were unable to or that are no longer engaged and your understanding of why; and
* How you have attempted to address these gaps in engagement

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

1. Please use the space below to describe any challenges you faced in implementing planned activities as described in the Action Plan and the cause of the challenges.

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

1. Please use the space below to describe any divergences from your final Action Plan made in order to successfully conduct your Community and Health Neighborhood Engagement, including those made to address the challenges described above.

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

# Environmental Scan Findings

Please see Appendices I and II for checklists that may be useful in responding to these questions.

Please note that the word limits are guidelines. You may exceed them as necessary to fully respond to the question or information request.

IV.a. Please use the space below to describe how the hospital has defined the community (based on input received).

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

IV.b. Please use the space below to identify the sources and information used to identify community health needs and service levels available including specific to the HTP priority populations and project topics.

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

IV.c. Please use the space below to describe any data gaps encountered while conducting the environmental scan, and how these were accounted for.

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

IV.d.i. Please use the space below to provide an overview of the hospital’s service area, including providing basic information about the demographics of the general population and the Medicaid population, including related to:

* Race;
* Ethnicity;
* Age;
* Income and employment status;
* Disability status;
* Immigration status;
* Housing status;
* Education and health literary levels;
* Primary languages spoken; and
* Other unique characteristics of the community that contribute to health status.

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

IV.d.ii. Please also provide information about the HTP populations of focus within the hospital’s service area, including:

* Individuals with significant health issues, co-occurring conditions, and / or high health care utilizers;
* Vulnerable populations including related to maternal health, perinatal, and improved birth outcomes as well as end of life care;
* Individuals with behavioral health and substance use disorders; and
* Other populations of need as identified by your landscape assessment. Please consider those at-risk of being high utilizers to whom interventions could be targeted. This should include populations that may not currently receive care in the hospital but are known to community organizations and reflected in the response to IV.d.i.

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

IV.e.i. Please use the space below to describe the prevalence of significant behavioral and physical health needs generally in your service area, specifically citing the service area’s top behavioral health, substance use, and chronic disease burdens for both the Medicaid and the general population. Include rates for:

* Serious Behavioral Health Disorders;
* Substance Use Disorders including alcohol, tobacco and opiate abuse; and
* Significant physical chronic conditions.

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

IV.e.ii. Please also specifically address other significant behavioral and physical health needs in your service area that align with the populations and project topics of focus within the HTP, such as:

* Top chronic conditions accounting for most utilization (include both physical and behavioral health chronic diseases);
* Physical health conditions that commonly co-occur with mental health diagnoses;
* Related to maternal health, perinatal, and improved birth outcomes; and
* Related to end of life care.

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

IV.f.i. Please use the following response space to describe the delivery system’s service capacity within the region and any identified gaps in direct or supporting care services. Assessments should address the state of capacity generally in the community, including community-based social services beyond medical services (i.e. housing and legal assistance, nutrition programs, employment services), as well as information specific to the HTP priority populations and project topics (including services for high utilizers, maternal health and end-of-life services and services for other vulnerable populations, those with behavioral health and substance use disorders, and population health interventions), and should specifically address:

1. Service availability, access, and perceived gaps generally as well as related to HTP priority populations and project topics, including related to:
2. Primary care;
3. Specialty care;
4. Long term care;
5. Complex care management;
6. Care coordination via primary care or other providers;
7. Maternal health, perinatal, and improved birth outcomes;
8. End of life care;
9. Behavioral health;
10. Other outpatient services;
11. Population screenings, outreach, and other population health supports and services; and
12. Any other areas of significant capacity gaps.
13. Qualified staff recruitment and retention concerns, particularly related to the services listed in (a).
14. Resources and gaps related to care transitions among specific populations or across major service delivery systems, including:

* Available resources and partners that can be leveraged; and
* Perceived gaps.

1. Social supports related to social factors impacting health outcomes specific to HTP priority populations:

* Available resources and partners that can be leveraged; and
* Perceived gaps.

Take into consideration the following community-based social services-resources:

1. Housing;
2. Homelessness;
3. Legal, medical-legal, financial;
4. Nutrition;
5. Employment and job training; and
6. Transportation.

Response (Please seek to limit your response to 2,000 words or less)

IV.f.ii. Please use the table below to identify the hospital’s facilities and services available in the community as the hospital has defined them.

| **Facility Type** | **Facility Name** | **Facility Address** | **Services Offered** |
| --- | --- | --- | --- |
| e.g., Hospital |  |  |  |
| e.g., Laboratory |  |  |  |
| e.g., Outpatient Clinic |  |  |  |
| e.g., School-based Clinic |  |  |  |
| e.g., Urgent Care Center |  |  |  |
| e.g., Free-standing Emergency Room |  |  |  |
| Other |  |  |  |

IV.g. Please use the space below to describe the current state of protected health data exchange infrastructure and use inside the defined service area (available RHIOs, participation level amongst area providers, primary data exchange capabilities) as well as an assessment of the hospital’s current capabilities regarding data exchanges across network providers, external partners and with RHIOs or regional data exchanges. Please speak specifically to how this impacts care, including care transitions and complex care management.

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

IV.h. Please use the space below to provide information about any other major topics discussed with community stakeholders and input received.

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

IV.i. Please use the space below to provide preliminary thinking regarding the likely focus of HTP initiatives, in particular target populations and target community needs.

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

# Planned Future Engagement Activities

V.a. Please use the space below to outline planned future activities for engaging community organizations and processes that will be completed to inform and develop the hospital’s HTP application. Please describe how organizations that serve and represent the broad interests of the community will continue to be engaged in the planning and development of the hospital’s application, including:

* Prioritizing community needs;
* Selection of target populations;
* Selection of initiatives; and
* Completion of an HTP application that reflects feedback received.

Please note that the word limit is a guideline and you may exceed it as necessary.

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

# Additional Information (Optional)

You may use the space below to provide any additional information about your CHNE process.

Please note that the word limit is a guideline and you may exceed it as necessary.

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

1. Community Inventory Tool[[1]](#footnote-1)

Use this tool to inventory clinical, behavioral, and social service resources in the community that could provide timely post-hospital follow-up, monitoring, and assistance. Use this inventory to identify which resources your hospital regularly uses. Also use this inventory as an implicit gap analysis to stimulate a consideration of providers or agencies you may want to more regularly use.

**Clinical and Behavioral Health Providers**

| **Provider or Agency** | **Transitional Care Services [Examples]** | **Yes** | **No** |
| --- | --- | --- | --- |
| Community health centers, federally qualified health centers | [ability to accept new patients; timely posthospital follow-up; co-located social work, nutritional, pharmacy services, etc.] |  |  |
| Accountable care organization with care management or transition care | [high-risk-care management, transitional care to reduce readmissions, etc.] |  |  |
| Medicaid managed care organizations | [high-risk-care management, social work, wraparound services, etc.] |  |  |
| Program of All-inclusive Care for the Elder (PACE), Senior Care Options (SCO), Duals Demonstration providers | [capitated or risk-bearing providers focused on providing whole-person care to improve quality and reduce costs] |  |  |
| Medicaid health homes | [engagement, outreach, tiered care management; eligibility based on chronic and behavioral health conditions] |  |  |
| Multiservice behavioral health centers, including beshavioral health homes | [prioritized posthospital follow-up; availability for new patients; co-located support services, etc.] |  |  |
| Behavioral health providers | [accepting new patients, prioritizing posthospital follow-up, etc.] |  |  |
| Substance use disorder treatment providers | [effective processes for linking patients from acute care to substance use disorder treatment] |  |  |
| Heart failure, chronic obstructive pulmonary disease (COPD), HIV, dialysis, or cancer center clinics | [urgent appointments for symptom recurrence, protocol-driven ambulatory management, social work, education, etc.] |  |  |
| Pain management or palliative care | [symptom management over time, often with behavioral health specialists and social workers, education, etc.] |  |  |
| Physician/provider home visit service | [timely post discharge in home evaluation, coordination with primary care, specialists, pharmacy, home health, etc.] |  |  |
| Skilled nursing facilities | [onsite providers, warm handoffs, joint readmission reviews, INTERACT (Interventions to Reduce Acute Care Transfers) processes, transitional care from skilled nursing facility to home, etc.] |  |  |
| Home health agencies | [warm handoffs, joint readmission reviews, front-loaded home visits, behavioral health clinical expertise, etc.] |  |  |
| Hospice | [warm handoffs, joint readmission reviews, same-day home visits, etc.] |  |  |
| Adult day health | [daily clinical, nutritional, medication management, socialization, etc.] |  |  |
| Public health nurses | [home visits, outreach, education, clinical coordination, etc.] |  |  |
| Pharmacies | [bedside delivery, home delivery, medication therapy management, affordability counseling, blister packs, etc.] |  |  |
| Durable medical equipment | [same-day delivery; 30-day transitional care monitoring, education services, etc.] |  |  |
| Other |  |  |  |

**Social Services**

| **Provider or Agency** | **Transitional Care Services [Examples]** | **Yes** | **No** |
| --- | --- | --- | --- |
| Adult protective services | [safety evaluation, case management] |  |  |
| Area Agency on Aging (AAA) | [self-management coaching, chronic disease self-management, in-home personal support services, etc.] |  |  |
| Aging and Disability Resource Centers | [evaluate for eligibility for benefits and services; link to vetted providers] |  |  |
| Assisted living facilities | [onsite clinical, onsite behavioral, self-management coaching, adherence support, transportation, etc.] |  |  |
| Housing with services | [care management, onsite social work, onsite clinical, nutritional/food support, transportation, etc.] |  |  |
| Housing authority or agencies | [case management, facilitated process of pursuing housing options] |  |  |
| Legal aid | [securing benefits, access to treatment, utilities, rent, etc.] |  |  |
| Faith-based organizations | [personal and social support, transportation, meals, etc.] |  |  |
| Transportation | [transportation to meet basic and clinical needs] |  |  |
| Community corrections system | [case workers, social workers, collaboration on follow-up] |  |  |
| Other |  |  |  |

1. Hospital Care Transitions Activities Inventory Tool[[2]](#footnote-2)

An inventory of readmission reduction efforts will reveal the administrative, clinical, health information technology, and other organizational assets already in place. Once you know what efforts and assets already exist, you can consider whether they are optimally aligned and coordinated. The inventory will also serve as an implicit gap-analysis of activities or assets not currently in place. You may identify the need to implement new practices as part of this process.

**Readmission Activities/Assets**

| Administrative Activities/Assets | **For Which Patients?** |
| --- | --- |
| Specified readmission reduction aim |  |
| Executive/board-level support and champion |  |
| Readmission data analysis (internally derived or externally provided) |  |
| Monthly readmission rate tracking (internally derived or externally provided) |  |
| Periodic readmission case reviews and root cause analysis |  |
| Readmission activity implementation measurement and feedback (PDSA, audits, etc.) |  |
| Provider or unit performance measurement with feedback (audit, bonus, feedback, data, etc.) |  |
| Other: |  |

| Health Information Technology Assets | **For Which Patients?** |
| --- | --- |
| Readmission flag |  |
| Automated ID of patients with readmission risk factors/high risk of readmission |  |
| Automated consults for patients with high-risk features (social work, palliative care, etc.) |  |
| Automated notification of admission sent to primary care provider |  |
| Electronic workflow prompts to support multistep transitional care processes over time |  |
| Automated appointment reminders (via phone, email, text, portal, or mail) |  |
| Other: |  |

| Transitional Care Delivery Improvements | **For Which Patients?** |
| --- | --- |
| Assess “whole-person” or other clinical readmission risk |  |
| Identify the “learner” or care plan partner to include in education and discharge planning |  |
| Use clinical pharmacists to enhance medication optimization, education, reconciliation |  |
| Use “teach-back” to improve patient/caregiver understanding of information |  |
| Schedule follow-up appointments prior to discharge |  |
| Conduct warm handoffs to post-acute and/or community “receivers” |  |
| Conduct post discharge follow-up calls (for patient satisfaction or follow-up purposes) |  |
| Other: |  |

| Care Management Assets | **For Which Patients?** |
| --- | --- |
| Accountable care organization or other risk-based contract care management |  |
| Bundled payment episode management |  |
| Disease-specific enhanced navigation or care management (heart failure, cancer, HIV, etc.) |  |
| High-risk transitional care management (30-day transitional care services) |  |
| Other: |  |

| Cross-continuum Process Improvement Collaborations With: | For Which Patients? |
| --- | --- |
| Skilled nursing facilities |  |
| Medicaid managed care plans |  |
| Community support service agencies |  |
| Behavioral health providers |  |
| Other: |  |

1. Adapted from: Designing and Delivering Whole-Person Transitional Care. Content last reviewed June 2017. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html [↑](#footnote-ref-1)
2. Adapted from: Designing and Delivering Whole-Person Transitional Care. Content last reviewed June 2017. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html [↑](#footnote-ref-2)