Colorado Hospital Transformation Program (HTP)

Frequently Asked Questions (FAQ)

Date: October 14, 2022

Contents

I. Community Health Neighborhood Engagement (CHNE)

General

Q: Are there are any guidelines/templates/requirements for CHNE Reporting?

A: Yes, please refer to the Community and Health Neighborhood Engagement (CHNE) Process section on the HTP website, which includes the guidebook, requirements overview, templates, and other resources. Additionally, hospitals can reference the Quarterly Reporting Tool in their CPAS accounts or review prior training materials, which are also posted to the HTP website.

Q: Are you all collecting information across hospitals the feedback from the engagement meetings to share best practices with all of us?

A: That is correct, we will be collecting the information over time to understand the types of feedback received. We hope this information will help us and provide additional guidance to hospitals moving forward.

Q: Do you envision any of the reporting requirements changing over the span of the 5 year program when it comes to reporting quarterly? Or what you see today is what we will report on for the next 5 years?

A: The requirements outlined for CHNE reporting will not change over the course of the program.

Q: Is supporting documentation required for CHNE reporting?

A: No, documentation is not required for continued CHNE reporting. Documentation will be important for demonstrating milestone completion.

Q: Will we be able to download our responses to keep a historical record?

A: A quarterly reporting summary will be sent out via email once the survey has been submitted. The summary will include a record of all responses.

Q: Can we enter information into the survey throughout the quarter rather than using the Quarterly Reporting Tool Excel sheet?

A: The survey will not be available until the first business day after the end of the quarter. Therefore, we recommend hospitals use the Quarterly Reporting Tool or other internally developed template/tool to prepare for quarterly reporting in advance.

Q: Do I need to complete sections of the survey for types of engagement that did not occur in the applicable quarter? For example, if we didn't have a public input engagement this quarter, do we need to answer those questions?

A: The first question in the CHNE section is a radio button indicating which types of CHNE occurred during the quarter (consultations with key stakeholders, community advisory meeting, public engagement). Questions will populate in the survey based on that selection. Therefore, if public engagement was not selected, those questions will not populate in the survey.

Q: For the Quarterly report, do we only enter those community stakeholders that we worked with for this quarter or include past organizations too?

A: Focus only on what engagements there were in this quarter. The only exception is for the public input meeting required in PY1. Public input meetings that occurred in quarter 2 (January-March 2022) may count towards PY1Q3 CHNE.

Q: Will hospitals be penalized or deemed incomplete if they meet the minimum reporting requirements for the quarter, and additional engagements were unsatisfactory?

A: No, it would not count against the hospital. If there is an error or incomplete response that doesn't impact the ability to meet the requirements, the reviewers are making a learning note, but it would not be considered incomplete.

Requirements

Q: What are the CHNE requirements for year 1?

A: In Program Year 1, CHNE includes the following activities, at a minimum: consultations with key stakeholders in quarters 3 and 4 and public input meeting in quarter 3 or 4. Public input meetings that occurred in quarter 2 (January-March 2022) may count towards PY1Q3 CHNE.

Q: Can we combine the key stakeholder meeting with community advisory as one event?

A: For PY1Q3 and PY1Q4, community advisory meetings can count towards meeting the CHNE requirements for key stakeholder engagement but should be reported as Community Advisory Meetings.

Q: For part of our routine CHNA process we held a town hall for community input, including on HTP measures, in October 2021. But since it wasn't in PY1Q3 or Q4 that can't count for the public input meeting?

A: Correct, that did not occur in PY1Q3 or Q4. We have made allowances to allow events occurring in Jan-Mar 2022 to count towards PY1Q3. This allowance is applicable to program year 1 only.

Q: For the CHNE requirements, do we need to have measure specific meetings/engagements per hospital per measure? For example, if we were to meet with a Behavioral Health Community Provider would that satisfy the CHNE for that hospital or would

we have to also schedule separate meetings with other stakeholders to cover the other measures? Also, would it be okay if we had one shared meeting/engagement where more than one hospital was present or do we need to have separate meetings/engagements per hospital?

A: We are looking for each hospital to report on the engagement they had with their community and/or stakeholders that quarter regarding HTP. It is not by measure. Multiple hospitals can be included in engagement but the engagement only counts if the hospital is actively discussing their particular program and interventions and not for hospitals that are only a passive attendee in the meeting/engagement.

Q: We are forming a hospital collaborative with representatives from all the regional hospitals. As part of the CHNE reporting, how should the collaboration be reflected? Do we list out all the different hospitals separately, or do we give this group a name and list it?

A: If multiple hospitals come together and meet with a specific organization i.e. HIE, RAE, etc., the CHNE should focus on the engagement with that community organization outside of HTP participating hospitals. The collaboration with other hospitals is great, but hospitals should focus their CHNE and reporting mostly on engaging stakeholders and organizations outside of hospitals. Project planning activities between hospitals will be part of interim activity and milestone reporting. Hospitals do not want their engagement to appear to be predominantly hospital-centric. The audience for your reporting is your community and the public as well as the HCPF review team and the state. If there is significant engagement between hospitals that is an important key stakeholder engagement, then hospitals should list that as Regional Hospital Collaboration, and include one line item with multiple dates in the CHNE reporting instead of reporting each hospital separately, and list it as key stakeholder engagement. With key stakeholders you can add more info in the "type of organization" block if deemed necessary; i.e. group of hospitals including x, y, z, etc. For community advisory you will be able to include the list of the organizations involved.

Q: Some of the terminology used for CHNE is unclear. Can you clarify the differences between "consultation with key stakeholders", “community advisory meeting”, and "public engagement"? What does each term mean and what might qualify?

A: The different types of community engagement are detailed in the "Ongoing CHNE Requirements" document. This document can be found on the COHTP webpage, under "Community and Health Engagement Process".

Consultations with Key Stakeholders

Q: In each quarter, will we be expected to meet with majority of our key stakeholders?

A: We want to know who you met with, but there is no minimum threshold on each quarter in terms of types of organizations or number of meetings. We have some recommended thoughts, as laid out in the Ongoing CHNE document. Depending on which

quarter, you will have different levels of engagement – and we understand that. We will be reviewing your engagement over time. If a hospital is only engaging with one stakeholder each quarter, we may flag those and reach out.

Q: If I meet with two stakeholders in one quarter does that count as two meetings?

A: It will count as two meetings within that quarter, but we would need to see consultations with key stakeholders in at least one other quarter to satisfy the annual requirement.

Q: We have a Patient Family Advisory Council. Can this count as public engagement if we speak specifically about our HTP projects?

A: The intention around public engagement is for the general public to be able to have information and provide feedback around HTP, which is more broad than your PFAC. We want the public engagements to be more wide reaching. PFACs can count as consultations with key stakeholders.

Q: Next quarter, will organization information pre-populate or will we need to re-enter everything? We will likely meet with many of the same organizations every quarter.

A: For consultations with key stakeholders, the organization name will pre-populate in future quarters. The contact information will need to be re-entered every quarter. You can use the hospital quarterly reporting tool to paste information into surveys rather than starting from scratch.

Q: If a hospital completed the Community Health Needs Assessment (CHNA) during this quarterly reporting period, should it be reported as CHNE?

A: The completion of the CHNA itself does not qualify as CHNE; however, if there were engagements with stakeholders to prepare or review the CHNA where HTP was specifically discussed, those engagements could count as consultations with key stakeholders.

Q: Would secondary one-on-one meetings following the annual public input meeting count as a Consultation with Key Stakeholders?

A: If these individuals have been identified as key stakeholders that will be regularly engaged to discuss HTP updates and provide input and feedback, yes they may be listed in the key stakeholder section of the CHNE survey. If that is not the case, they should not be included.

Q: If a hospital has met with two individuals with entirely different roles but they are from the same organization, can the hospital list the organization twice under key stakeholders, and then list each of their names under the primary contact?

A: Please list the organization once. List both contacts if you believe they are both equally primary contacts or choose one contact to list. Then list each date you met with that organization.

Community Advisory Meetings

Q: During community advisory meetings can we focus on common interventions (i.e. social needs screenings) rather than reviewing the entire implementation plan that may not be applicable to all stakeholders present?

A: Yes, hospitals can focus in on common interventions or interventions that are applicable to the stakeholders present. Community advisory meetings can serve as opportunities to workshop with other subject matter experts in the industry on specific HTP initiatives pertinent to your hospital and the stakeholders gathered.

Q: We can count the participants at the community advisory committees as consultations with key stakeholder for two of the four quarters. Am I interpreting that correctly?

A: For every year starting in PY2, hospitals are required to address consultations with key stakeholders two quarters, community advisory meetings in two different quarters, and public engagements just once.
If you don't have a community advisory meeting that quarter, you must have consultations with key stakeholders. If you have a community advisory meetings with stakeholders there, count it as a community advisory meetings not consultations with key stakeholders.

Q: Can participation at PIAC through our RAE count as community advisory meetings for those hospitals that do not have one in place?

A: If the RAE is organizing a PIAC meeting around HTP and gets feedback regarding HTP, then yes. The hospital should be engaged and sharing information regarding their specific HTP program with the PIAC in order for it to count as a community advisory meeting. You don't have to host a meeting for it to count. In some cases, if you participate in larger group discussions about HTP, it should suffice. It is so important that the discussions do include conversations about HTP.

Public Engagement

Q: If several hospitals in the area come together to hold the public meeting together, can we each count that?

A: If each hospital is presenting around their HTP and allowing for public feedback for each hospital's program, yes. If only one hospital is presenting, but others are attending, it would not count for those only in attendance.

Q: Is it correct that virtual public input meetings are allowed?

A: Yes, virtual meetings are an option. Hybrid and in-person are also options.

Learning Symposium

Q: Will there be a virtual option for the Learning Symposium?

A: As a reminder, it is an annual CHNE requirement to attend the Learning Symposium. Yes, there will be a virtual option.

II. Interim Reporting

General

Q: For interim reporting, can interim reporting only be used towards our upcoming milestone or can it be progress towards any milestones included in the implementation plan?

A: We want it to be predominantly focused on the upcoming milestone to ensure you're on track and that we're progressing as planned; however, if you would like to report additional information for work towards future milestones may do so.

Q: Are there any concerns if our interventions have similar interim activity?

A: The interim activities completed may be similar across multiple interventions, but most likely have an intervention specific component. Hospitals should address the intervention specific component when describing interim activities.

Q: Is it appropriate to notate any issues/challenges the hospital identified, even if we are on target to meet the milestone?

A: If you're still on track to meet the upcoming milestone, you may include identifying barrier(s) and mitigation strategies as a part of your interim activities. If barriers are not related to the upcoming milestone, the barrier should not be included in the interim activity report.

Q: If we've already achieved the upcoming milestone, and report that achievement in our interim activity report, what do we report in the next interim activity report for the same upcoming milestone?

A: As indicated, address that the milestone has been completed. In future quarters you may address other activities that have occurred in the process of implementing the intervention. If you find yourself substantially ahead of where you thought you'd be, consider amending future milestones during milestone reporting.

Q: If a hospital indicates they are at risk for not meeting the upcoming milestone during interim reporting, how is this information used?

A: The Department will assess responses indicating hospitals are not on track to meet the upcoming milestone after all submissions have been reviewed. The Department will provide outreach and guidance as needed. Reporting on any concerns or risks does not impact your score negatively.

Q: There are three interim reports due previous to our first milestone report, correct? So, we will report three times on how we are progressing towards the first milestone?

A: Yes, there are 3 interim activity reports due before PY2Q2 milestone report; this includes PY1Q3, PY1Q4, and PY2Q1.

Q: Our first milestone says that we will build out a dashboard to track performance as part of our technology work. However, we have other technology work we are doing to build the measure (i.e. patient identification). Can we report on the technology development for patient identification even though our first milestone is related to dashboard building?

A: At a minimum, we will be reviewing to ensure what you have written crosswalks to your upcoming milestone. You can include additional information related to a particular functional area or future milestone; however, you don't want to include that information in lieu of what is applicable to the upcoming milestone. For this particular example, you could report on the progress for patient identification and explain how that is a necessary preliminary step before the hospital can build out the dashboard included in the first milestone.

Q: Do we need to report interim activity for each intervention, for the interim report to be considered complete?

A: Yes. Interim activities are required to be reported for each intervention. The survey will pre populate each intervention and the hospital will have to answer the interim activity questions for each intervention. CHNE is reported hospital wide while interim activity is reported by intervention.

Q: Just to confirm, we do not need to submit supporting documentation for interim activities?

A: Correct. Supporting documentation is not required for interim activities.

Q: What is expected to be submitted for the "interim activity" reports?

A: Hospitals will be asked questions via a Qualtrics survey regarding their progress towards the upcoming milestone, whether progress towards milestone completion is on track, and if not, what support may be needed. These are narrative based responses and no supporting documentation is required. The questions that will be asked are included in the Quarterly Reporting Guide published to the CO HTP website and within the Quarterly Reporting Tool.

Q: If the hospital's submission is complete and on time, would there be any additional comments in the determination letter such as best practices? Or should hospitals only anticipate comments if incomplete?

A: Comments will only be included in determination letters where submissions were deemed incomplete. The review team is compiling learning notes to discuss during the monthly hospital workgroups.

Q: If a hospital addresses a functional area that is not part of an upcoming milestone but the activity listed is still related to the upcoming milestone, will the interim activity be considered incomplete?

A: Hospitals should address at least one functional area of the upcoming milestone. Even if no progress has been made on the functional area specified in the hospital's Implementation Plan, the hospital should address that and the response will still be considered "complete" for the purposes of reporting.

Functional Areas

Q: For interim activity reporting, if there is more than one functional area in a milestone (e.g. people, process) but the hospital has not done any work, or no significant work, under one of the functional areas in the quarter, can we just indicate that in the survey?

A: Yes, you are not required to have worked on all functional areas during the interim activity period, as long as the hospital is still on track to meet the upcoming milestone. For functional areas included in the upcoming milestone where activities have not been started, it would be helpful to notate. Otherwise, the response may appear incomplete.

Qualtrics Survey

Q: Will we be able to download our responses to keep a historical record?

A: A quarterly reporting summary will be sent out via email once the survey has been submitted. The summary will include a record of all responses.

Q: What should the hospital do if there is a need to navigate back to make updates in the survey?

A: Go through all responses before you progress to review page. If you progress to the review page and need to make a change, email tech support (cohtp@mslc.com) to determine if the change warrants issuing a retake link.

Q: Is it a problem that the hospital submission did not include the date with the signature on the attestation?

A: No, that will not be an issue because the submission date is recorded with responses.

Scoring Review and Reconsideration Period

Q: For interim reporting, if the progress that a hospital described towards their milestone has been insufficiently communicated or the hospital believes it was misunderstood by reviewers, will hospitals have the opportunity to make an argument to support our responses are complete and aligned with the milestone?

A: Hospitals can submit a Scoring Review and Reconsideration request form following initial determinations. This is the hospital's opportunity to request reconsideration of initial scores if they believe their submission has been scored in error. As a reminder, no revised submissions will be accepted during the Scoring Review and Reconsideration Period (SRRP).

III. Milestone Reporting

General

Q: In the first milestone report (submitted at the end of PY2Q2- April 2023) is it true that hospitals can report on the activities they completed from November 2021 through March 2023? So the first report would technically contain activities that occurred over the course of about a year and a half as opposed to most of the other reports, which will only contain activities that occurred over 6 months, right?

A: Correct. The first milestone report submitted in April of 2023 will include activities completed related to the PY2Q2 milestone, which may have occurred between the implementation plan approval in November 2021 through the end of PY2Q2.

Q: How does it work if we completed a milestone before the milestone reporting quarter? For example, one of our milestones was to have our initial kickoff meeting and this was already conducted.

A: Address that the milestone has been completed in the first milestone report. If you find yourself substantially ahead of where you thought you'd be, consider amending future milestones during milestone reporting.

Q: Submissions for milestones occur in the 30 days AFTER the end of the reporting quarter, right? So, milestone reporting for PY3Q2 would be due on October 31, 2024? Or would it be due on September 30, 2024?

A: Yes, milestones are reported in the thirty days after the end of the reporting quarter. However, PY3Q2 is January-March 2024, so the milestone reporting would be due by April 30, 2024. HTP follows the Federal fiscal year rather than the calendar year.

Milestone Amendments

Q: What are the requirements in terms of the frequency of milestone amendments?

A: Milestone amendments only occur during milestone reporting (Q2 and Q4 of program years 2-5). Milestones can only be amended for future quarters, not the current quarter.

Q: Can you amend the same milestone more than once as long as it's in the future?

A: Yes

Q: A future milestone states, "create transmission ADT report" for COE1. If we decide to go with a different type of report like CCD or something other than ADT, but still are creating a transmission report, do I need to make an amendment or is that level of detail not required? I'm hoping as long as we are still creating a transmission report, then the type isn't as big of a deal in my mind, but I wanted to confirm.

A: If the details of the milestone are accomplished and documented in the documentation, that's fine. But if the details of the milestone are no longer correct or will not be supported in the revised type of report, an amendment is needed.

Q: Do we need approval from HCPF before amended milestones can be considered official and binding?

A: Yes. Milestone amendments will be subject to the same review criteria as the implementation plans. Details are included in the Quarterly Reporting Guide.

Supporting Documentation

Q: Do you need supporting documentation in years 4-5 too for the milestones?

A: Yes. Although there is no at risk tied to meeting the milestones in those years, there is a requirement that documentation be submitted in order to meet the timely reporting requirement.

IV. Performance Measures

General Guidance

Q: Can you confirm that hospitals do not need to do anything in the performance phase other than continue to submit data if applicable? That is just when HCPF will be measuring hospitals, which overlaps with the planning & implementation and continuous improvement phases, correct?

A: Hospitals will be asked to report on performance measures that are not derived from claims data. For example, RAH4 is not calculated using claims data and will be reported by the hospital if the hospital selected that measure. The reporting tool used during the PY 0 Rehearsal Period will be used in subsequent years for hospital self-reported measures. Performance reporting for PY2 will occur in PY3Q2 (January 2024) and does occur

concurrently with planning and implementation and continuous improvement phases for milestones.

Q: Could you please let me know how you define “third party insurance clients”? Is that commercial insurance?

A: Third party does include commercial insurance. It is possible for Medicaid beneficiaries to have more than one source of healthcare coverage, and by law the third party resource must meet their legal obligation before the Medicaid program pays for care.

Q: Does “all Medicaid patients” include primary AND secondary Medicaid or just primary?

A: For all measures (excluding the readmission measure) only Medicaid Primary is included, so secondary and third party are excluded.

Q: When should hospitals expect to receive PY1 hospital self-reported measure workbooks for data submission, and will they download them from CPAS?

A: The PY1 performance measure data submission period will be January 2023. The MSLC team will be uploading new templates ahead of the submission period starting Jan 1.

Q: For measures with fixed numerical benchmarks already established that are not reliant upon the baseline data, such as the SW-CP1, what is the expectation for reporting on baseline data in January 2023 if a hospital is still building out the data tracking and reporting system at that time?

A: If a measure has a fixed numerical benchmark already established that is not reliant upon the baseline data, reporting incomplete or no data will not impact the hospital's performance or reporting for the HTP.

General Specifications

Q: Do any of the measures include dual eligible patients (Medicare and Medicaid)?

A: For hospital self-reported measures specific to the Medicaid population, this only applies to Medicaid primary patients and will exclude dual eligible, Medicaid pending, and emergency Medicaid patients.
For Medicaid claim measures calculated by HCPF, the population will exclude Medicaid managed care, dual eligible, Medicaid pending, and emergency Medicaid patients.

Q: On any of the measures that deal with inpatients, are patients that are admitted to observation included in the numerator

A: No, measures that are applicable to the inpatient setting exclude observation patients, unless otherwise noted.

Claims Measures

Q: Should we be validating the data hospitals received for claims-based measures or are you all confident in the accuracy?

A: Yes, we are confident and doing a lot of data validation and testing internally. However, we do want you all to review to determine if our calculations match your records and ensure you understand how the measures are being calculated.

Benchmarks

Q: For benchmarks, when you say the benchmark for PY3 is 80% does that mean hospitals should reach 80% during PY2 in order to receive funds in PY3 or does it mean they need to reach 80% by the end of PY3, which would then be analyzed/paid out in PY4?

A: The benchmark is related to the performance period. So the benchmark for PY3 is related to the performance period of PY3, which is 10/1/2023-9/30/2024. We will be collecting measure data annually in January for the prior program year, then we'll analyze the data and set benchmarks for the following year. Details are included in the Scoring Framework posted on the CO HTP website.

Q: Can you please clarify if we need to meet or exceed benchmarks in PY4 and PY5 or do we need to achieve a set percentage, like 5%, improvement in PY4 and PY5?

A: The first year for performance is PY3. You need to meet or exceed benchmarks in years 3, 4 and 5. The type of benchmark varies by measure. See the Scoring Framework or Measure Specifications posted on the CO HTP website for benchmark details.

Q: What does 5% improvement mean? Is that 5% relative or fixed?

A: The 5% is relative rather than fixed. For example, if the PY3 benchmark is 70% and the PY4 benchmark requires a 5% improvement upon the PY3 benchmark, the PY4 benchmark is **not** 75%. The benchmark is to improve by 5%. 5% improvement of a 70% benchmark is 3.5%. Therefore, the PY4 benchmark in this example would be 73.5%.

Performance Measure BH1

Q: SBIRT screening question - Do we have to use a specific screen to identify positive scores, or can we make that determination at the hospital level?

A: Screening instrument and scoring methodology used by individual hospitals must be consistent with CMS guidance and approved by the state. Please reference:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf
https://hcpf.colorado.gov/sbirt-manual

Performance Measure BH2

Q: Would administering medication internally or referring externally count towards the measure?

A: The measure includes the initiation of MAT. Whether you refer internally or externally is up to hospital.

Q: What if the patient has repeated admissions? Will each visit where MAT is initiated be included or only the initial visit?

A: The measure is counted by visit, not by patient. Any visit where the MAT is initiated would be counted.

Q: Does the MAT measure only apply to members seen in the ED and discharged home? Or does it also include members admitted through the ED?

A: All ED visits where denominator criteria are met should be included.

Performance Measure COE1

Q: For COE1, the measure specification is "Successful transmission of a summary of care record, as described in the intervention, to a Medicaid patient's PCP or other healthcare professional within one business day of discharge from an inpatient facility to home". What "other healthcare professional" would be acceptable?
Along this vein, could the patient's PCP be a health neighborhood, practice or a Federally-qualified health centers versus a named provider?

A: Healthcare professionals that would be appropriate to follow up with after the inpatient stay (i.e. a specialist). It is up to hospital/physicians to determine what is appropriate in terms of getting the summary of care to the next level of care.
Align with ACC and use portal to identify PCP. It does not have to be one specific person. It could be an organization name.

Q: For COE1, does this measure include inpatients discharged from a psychiatric unit?

A: The measure includes all patients discharged from an inpatient facility to home.

Q: For COE1, in the measure specification under Target Population Notes, it states Adult and Pediatric Medicaid (primary) patients. What is meant by the "primary" reference?

A: This refers to primary Medicaid which excludes pending Medicaid, emergency Medicaid, Medicaid managed care, and dual eligible (Medicare/Medicaid) claims.

Performance Measure CP6

Q: CP6 - Does this measure require that we screen patients that are pre or postnatal patients in the ED?

A: Yes

Q: When it says (60) days, is this only referring to the postpartum period and NOT perinatal (the sentence almost makes it seem like both)? If so, does this mean screening needs to happen within 60 days of birth to fit within this measure? Additionally, how often do we need to complete these screenings?

A: 60 days is referring to the postpartum period. 60 days after the baby is delivered.

Q: How often do we need to complete these screenings? Does screening have to be done for every visit?

A: The screen should be repeated for every visit if the prior screen was negative. If a screen is positive, no need to repeat in subsequent visits.

Q: For OP claims, are encounters for ancillary services like lab or imaging included or is this just specifically for OP ED or observation type visits in our inpatient units?

A: We are only looking at IP and OP hospital claims, not clinic visits or lab work.

Q: For CP6 (Pregnancy Screening Anxiety and/or Depression), our teams wanted to know what counts as outpatient hospital claims (OP). Would Observation and ED discharge?

A: Yes both would count as they are reported on Outpatient claims.
8.300.3.B Covered Hospital Services – Outpatient Hospital Services are a Medicaid benefit when determined Medically Necessary and provided by or under the direction of a physician. Outpatient Hospital Services are limited to the scope of Outpatient Hospital Services as defined in 42 C.F.R. Section 440.20. 1. Observation Stays Observation stays are a covered benefit as follows: a. Clients may be admitted as Outpatients to Observation Stay status. b. With appropriate documentation, clients may stay in observation more than 24 hours, but an Observation Stay shall not exceed forty-eight hours in length. c. A physician's order must be written prior to initiation of the Observation Stay. d. Observation Stays end when the physician orders either Inpatient admission or discharge from observation. e. An Inpatient admission cannot be converted to an Outpatient Observation Stay after the client is discharged. 2. Outpatient Hospital Psychiatric Services Outpatient psychiatric services, including prevention, diagnosis and treatment of emotional or mental disorders, are Medicaid benefits at DRG Hospitals. a. Psychiatric outpatient services are not a Medicaid benefit in free-standing psychiatric hospitals. 3. Emergency Care a. Emergency Care Services are a Medicaid benefit, and are exempt from primary care provider referral. b. An appropriate medical screening examination and ancillary services such as laboratory and radiology shall be available to any individual who comes to the emergency treatment facility for examination or treatment of an emergent or apparently emergent medical condition and on whose behalf the examination or treatment is requested.

Performance Measure CP7

Q: Do telehealth services count for expanding access to specialty care?

A: While we do have a separate telehealth measure for HTP, we would also accept telehealth visits as an appropriate approach for providing access to specialists.

Performance Measure PH1

Q: If a patient has an inpatient visit and their primary care provider is from outside of our hospital district (we have an associated Rural Health Clinic with PCP's) are those excluded? We can't know if they have a wellness visit if it is outside of our system

A: No they aren't excluded. PH1 is claims based so HCPF is pulling that information from Medicaid claims. The intervention is based on how the hospital plans to increase well visits. Measurement will be based on claims and hospital won't have to report.

Performance Measure RAE Notification Measures

Q: RAEs don't know what information they want. Is this something hospitals need to determine?

A: HCPF will be sending a flat file to indicate exactly what data is needed for applicable measures.

Performance Measure RAH1

Q: If a patient is refusing to allow the hospital to make a follow up appointment at discharge, as the measure requires, can this be excluded from the measure denominator?

A: The measure will not exclude these patients from the denominator. The measure does not expect 100% performance for earning at-risk and does not measure follow up appointment completion.

Performance Measure RAH4

Q: What are the state's thoughts on CMS's retirement of STK-06 (aka RAH4 data source) and the expectations for benchmarks/performance as it relates to the data source in future years after this is retired?

A: CMS was previously listed as the measure steward. While CMS is retiring the measure from certain Federal programs to focus on other priority areas, it is still a valuable and active measure. The measure steward will be corrected to the Joint Commission.

Performance Measure SW-BH1

Q: Can you please provide additional details or an example of how to execute a mutual discharge plan with the RAE for every patient with a primary or secondary mental illness or SUD diagnosis? What constitutes a 'mutually agreed upon discharge plan'? There is an extremely high volume of patients with secondary mental illness or SUD diagnoses seen in the ED. Many patients have a secondary diagnosis of Nicotine dependence, but are seen for an unrelated injury. I am not sure how staff will connect with the RAE to plan the discharge for all of these patients.

A: Mutually agreed upon does not mean the discharge planning process has to be mutually executed between the hospital and the RAE every time there is a discharge. It also doesn't mean the patient has to agree with hospital and RAE. We want to emphasize the importance of collaboration with the hospital and RAE on the front end. These two parties agree on how the discharge process is going to work.

Q: Obtaining coding that will give us our primary or secondary diagnosis will never occur within one business day - allowing us to notify the RAE within one business day - our coding usually takes 72 hours at a minimum. How is this concern being mitigated?

A: Hospitals should use admission diagnosis/ reason for visit rather than final diagnosis.

Q: Very rarely will you see someone with SUD as an admission diagnosis. How should that be handled for SW-BH1?

A: That is a great point and a reason why the intervention is important - to help identify these conditions as soon as possible.

Q: The measure specifications indicate notifying the RAE of principal/secondary dx of mental illness or SUD within one business day. Is this referring to one business day of discharge?

A: Yes, that is correct one business day from discharge.

Q: Does marijuana and tobacco count as substances for pregnant patients?

A: The measure does not differentiate between maternal and other patients. The patient needs to have a diagnosis of SUD. The diagnosis codes are listed in the HTP measure specs and are in line with the covered services under the Regional Accountable Entities.

Q: The measure specs discuss patients discharged from the hospital or emergency department. We're assuming hospital is referring to the inpatient setting; however, does this also include observation?

A: The measure includes inpatient and emergency department patients discharged to home. If observation is occurring in the emergency department those patients can be

included. If patients are seen in a non-ED outpatient setting they should not be included. If the observation results in an inpatient admission, they can be included.

Q: For patients who are transferred to a behavioral health facility, are they also included in this measure? Meaning we are to notify the RAE within one business day of transfer?

A: The measure only includes patients discharged to home. Transfers are not included.

Performance Measures SW-BH3

Q: Would Suboxone count towards ALTOs for patients with SUD? Will it be one of the medications that are part of opioid lists?

A: Generally speaking, CHA is aware that there are some medications, both ALTOs and Opioids that may not be captured in the measure specifications document that hospitals will use over the course of the next 5 years. However, when CHA originally compiled that list, they aimed to include the most frequently used ALTOs and Opioids. For hospitals to continue to be judged on the same medications throughout the course of the program, CHA has tended to not amend the ALTO and opioid lists as they believe the current list meets the intended goal. Further, since Suboxone is technically an opioid that is typically used to treat OUD and very rarely for analgesia is does not really fit the criteria of a medication that would be part of this measure. If you have any additional questions or concerns about this though, please reach out to the CHA.

Q: For the ICD-10 CM primary and secondary codes ranges, will we get a more specific list so that our teams know if any diagnoses are excluded?

A: Although we do list inclusion and exclusion code ranges, effectively any diagnoses that are not in the inclusion criteria are excluded.

Performance Measure SW-CP1

Q: Do hospitals have to identify if the patient “refuses” to take the screener? Or is the denominator based only on those who elected to be screened?

A: If a patient refuses screen for all 5 screening domains, they can be excluded entirely from the measure. However, if the patient answers screening questions for 1 or more domains, the screen should be included in the measure.

Q: If we've done a social needs screening through the clinic, but a patient is being seen in the ED, does the clinic SDoH screen count? Or does the ED need to conduct a new screen to meet the SW-CP1 metric? To elaborate, since our ED and clinics both use EPIC, the ED would be able to see in EPIC that the social needs screener has been completed.

A: A new social needs screen should be conducted for every new visit. Prior screens can and should be reviewed to allow for a more meaningful conversation with the patient regarding their needs.

Performance Measure SW-COE1

Q: What is the target population for the Hospital Index measure?

A: The target population at the broadest level consists of Medicaid patients that receive services under the associated procedural codes.

Q: Does the Hospital Index tool drill down to the Medicaid population?

A: Yes, the tool includes the Medicaid population and can drill down to claim and patient-level detail, including episodes.

Q: Is the intervention relating to the process hospitals put in place to address the data in the Hospital Index as opposed to the outcomes?

A: The intervention for the Hospital Index measure is how hospitals are using the tool to build a continuous learning and improvement environment. It should result in informing delivering of care downstream. The intervention should be addressing those processes the hospital puts in place to use the data to inform care delivery, not on outcomes within the procedure types.

Q: When will Hospital Index be updated with more current data, and how current will it be?

A: Data updates during the HTP will be every April. There are multiple updates and revisions as part of the data dress rehearsal so the update for 2022 will be in June.

Q: What is the benchmark for the Hospital Index measure? Is the goal a score of 100 for everyone?

A: There will be no benchmark for PY3 and all at-risk will be granted. The benchmark for PY4 and PY5 will be performance against the Index benchmark of 100.
If your hospital score is higher than 100 then you have actionable costs that are higher than the average and if your hospital score is lower than 100 you are performing better. The initial Index of 100 will be fixed and not recalculated each year so that hospitals' performance can be measured against a fixed target.

Q: In the implementation plan for the hospital index, some of the data requested is on race to further evaluate the top 5 episodes to improve. We noticed that data is not included in the hospital index. Do you have any insight on where or how we can find this data?

A: There are filters/toggles available within the dashboards for race/ethnicity, age, and gender. Episodes can also be filtered by Category of Service.

Performance Measure SW-PH1

Q: Are the following populations included in this measure: IP rehab, newborns, BH Stays?

A: Yes, inpatient settings include inpatient hospitals, birthing centers, inpatient psychiatric facilities, and residential substance abuse treatment facilities.

V. Implementation Plan

General

Q: This is a 5 year plan, some planning areas may not be immediately foreseen. What are the capabilities of changing implementation down the road, if it is required?

A: In the first 3 years, hospitals have the opportunity to amend milestones and change their approach to interventions. In years 4 and 5, hospitals are in continuous learning and improvement. That learning system is expected to help hospitals identify changes that may be needed to interventions.

Q: Are hospitals penalized for making adjustments?

A: There is no penalty for making adjustments. The at-risk dollars are connected to whether a hospital hits a milestone or not. There is also one chance per intervention where if a hospital does miss a milestone, a corrective action plan can be submitted and half of the at-risk dollars can be earned back.

Q: Is September 1st the earliest a hospital can access the template in the Collaboration Performance and Analytics System (CPAS)?

A: Yes. It will be the earliest that the collection tool will be available. However, the template and review criteria documents are available now on the Colorado HTP website.

Q: When submitting our implementation plan, we will be using some tool to guide us through the process. I would like to have a document where we can just copy and paste. What would be the best way to do that?

A: A template was developed and emailed to hospitals on August 31, 2021 to help hospitals with the implementation plan process. Hospitals may also contact the Department to request the template.

Q: Does section II only have to be submitted once for the overall implementation plan and then the sections IIIA and IIIB submitted for each intervention or does section II have to be submitted for each intervention?

A: Section II is only submitted once and applies to all interventions.

Q: Question III.A.5: If an individual's name is not known or will be determined after hire, what do we include? Can we indicate "unknown"?

A: If you know the individuals, include. If you don't know who the person will be, but you know what the role will be, include that and indicate the individual will be hired. The hiring of/ identifying the specific individuals could be a milestone activity.

Q: If there is more than one contact for a single role for an intervention, can we list both?

A: Each intervention will allow up to 5 contacts to be listed. However, if there are multiple contacts for the same role, please put them on separate lines or select the primary contact to list.

Q: Regarding administrative roles in question III.A.5, what types of individuals are you looking for?

A: Individuals that play a role in the leadership of the intervention. Specifically include leadership on the intervention level rather than the organizational level. Other individuals that contribute to the success of the intervention, such as local physicians, would be identified as part of the "people" functional area milestones.

Q: Regarding questions III.A.7b-c in the implementation plan, hospitals are asked to describe what functions and resources are already in place, or are not in place and will need to be re-purposed from other areas, built, acquired, or secured through a partner or in some way. Is this just a place to elaborate on our documented milestones or are you expecting more here?

A: These questions are asking about project planning; what is already established versus what will need to be developed from scratch. Even if it is a new intervention you'll have resources and functional capabilities in place and should describe how you're building on your current competencies to develop this new intervention.

Q: Can you talk more about the correction period after the implementation plan is submitted?

A: Following the submission due date, the Department will have 20 business days to review and score all Implementation Plans. At the conclusion of the review period, participating hospitals may receive a request for information (RFI) or receive notification that the Implementation Plan has been approved without RFI. Hospitals that receive an RFI will have 10 business days to complete revisions within the implementation plan submission tool. Revised implementation plans will be reviewed within 10 business days. If subsequent revisions are needed, the same time line will be repeated.

Q: In section III.A.7 (major functions and resources that are in place or need to be put in place) does each part of that question need to address all four functional areas? If you

address, for instance, a process you have in place already in the first part of the question and then note people, data, and patient engagement components that are not yet in place, will that suffice?

A: Yes, you do not necessarily need to address that functional area again. We want to make sure you are looking at the intervention holistically across all functional areas.

Q: Can there be more than one person leading the implementation of the intervention?

A: Yes, more than one person is acceptable.

Q: Question III.A.8 asks what major challenges and risks to intervention implementation exist and how the hospital will mitigate those challenges and risks. The question asks hospitals to address engaging difficult to reach populations in the response. What population(s) are hospitals supposed to address? The target population for the intervention or some sort of subset that is particularly difficult to reach?

A: Hospitals should base their response on the intervention. The hospital can address the target population as a whole, or if there is a subset that is particularly difficult to reach that the hospital needs to focus their efforts on, they can identify that in the response.

Qualtrics

Q: Regarding the Qualtrics submission, can we add content, save, then return to finish in another session?

A: Yes - every time you move to another page the content saves. Do not submit until you are completely finished.

Q: How many hours are you anticipating it will take to cut and paste our Implementation Plan information into the Qualtrics portal?

A: We estimate about 30 minutes when the implementation plan template was fully completed.

Q: Would it be possible to get more than 2 logins to Qualtrics to complete the implementation plan?

A: Every hospital has received a Qualtrics link that is unique to the hospital. The link can be shared with others within the hospital; however, only one person can be in Qualtrics editing/entering information in the implementation plan survey at a time. A good solution would be to utilize the template if you have multiple team members working on the implementation plan.

Q: Does Qualtrics have a review page where you can review all responses at once before submitting?

A: Not at this time, but hospitals can use the percentage complete to confirm there are no missing responses. Additionally, utilizing the template will help in your review/finalization process before inputting in Qualtrics.

Q: Can I list multiple activities and supporting documentation under one functional area for a milestone reporting period?

A: Yes; however, it is very important that distinct activities and their corresponding documentation are numbered to prevent confusion once the information is transferred from your template into Qualtrics. See "Implementation Plan Numbering" tab for example. Please note that this is purely for illustrational purposes. Hospitals are not required to list multiple activities per functional area in one quarter and are only required to describe one piece of supporting documentation per distinct activity.

Q: Sometimes my answers in Qualtrics disappear. What do I do?

A: When done you're typing in a box, click out of the box and the response will automatically save. If the cursor is still flashing in the text box, the answers will not have saved. Also, limit the amount of users editing the survey at once to one person to avoid overwrite issues.

Q: How do I get a PDF of my implementation plan responses?

A: As a newly added feature, hospitals will be able to review the responses submitted as well as download a pdf of responses logged. (If you had opened up the link prior to our team pushing out this function, you may not be able to see the review page.) See Appendix B for more information.

Q: Can multiple individuals work on the survey via the retake link.

A: Unfortunately, no. Unlike the original survey links, the retake links do not have a collaboration capabilities. At this time, only one individual (on the same browser and the same computer) should retake the survey in Qualtrics. Sharing the survey retake link with multiple people creates separate records in our system, so hospitals will not be able to input information separately into one record. Our team will then not be able to validate which record is correct.

Q: What if multiple individuals from my hospital click the retake link in the RFI?

A: New records will be generated every time the link is clicked on a new computer. Those records do not “talk” with each other. Only responses that are actually submitted will be recorded and captured for MSLC review. Please ensure only one response is **submitted**, even if multiple people open the link.

Q: If I get more than one RFI, can I use the same retake link?

A: No. A separate and distinct retake link will be provided that corresponds with each RFI letter. Please see Retake Link Flow Chart in Appendix C for graphic of the process.

Milestones

Q: Can I use measure performance metrics as milestones?

A: It is not recommended that the hospital tie milestones to measure performance. This creates a situation where measure performance impacts at-risk funds for both milestone achievement and measure performance.

For planning and implementation phase milestones, the hospital may instead describe any structural activities or steps (e.g. staff training, gap assessments) that document progress toward fully operationalizing this intervention. While the hospital may arrive at the desired measure outcome through implementation of these steps, milestone descriptions are not required to address metrics of success.

For continuous improvement phase milestones, the hospital may instead describe activities that document progress toward deploying quality improvement teams, cycle completions for quality improvement exercises or the development and use of various types of quality improvement forums, technical assistance programs or other quality improvement capacity development.

Q: What does a milestone include? Can one milestone include multiple components?

A: A milestone represents where the hospital is going to be with the implementation of the intervention at a point in time and can include multiple components.

Q: What if we have milestones that apply to multiple interventions?

A: The milestones may be similar, but there should be distinctions specific to each intervention.

Q: You mentioned each intervention will have 8 milestones. That includes the planning and implementation phase and continuous improvement, correct? So will we need to have the description and supporting documentation for the 8 milestones?

A: Correct. There will be eight total milestones for the following reporting periods: PY2Q2, PY2Q4, PY3Q2, PY3Q4, PY4Q2, PY4Q4, PY5Q2, PY5Q4. For planning and implementation milestones, a description of the functional area and documentation for each applicable functional area is required. For continuous learning and improvement milestones, there are no functional areas. Therefore, only a description of the overall milestone and documentation is required.

Q: It seems for example in the social determinants of health example (and others), we will want to be fully implemented before PY3Q2 as there will be benchmark and

achievements at risk. If we are early, would we hold off on submitting the documentation until PY3Q4 or could that be submitted in PY3Q2?

A: New interventions should be fully implemented no later than PY3Q4 and existing interventions no later than PY3Q2 and can be fully implemented earlier. The implementation plan should be developed and reflect the intended fully implemented timeframe and move to continuous learning and improvement.

Q: With regards to measures that involve notifying the Regional Accountable Entity (RAE), can we be vague in our notification process in the milestones since the RAE has not been active in reaching out and communicating the process they can accommodate.

A: Working with the RAE needs to be part of implementation planning. Earlier milestones may be working with RAE to develop notification process and protocols. The process outlined can be high-level.

Q: If in a single milestone reporting period, I select people functional area and I wanted to say I hired someone and established a committee. What does that look like to report in Qualtrics? Are they typed out separately or within the same box? Can we upload more than one supporting document to indicate both things were completed?

A: The activities related to a particular functional area for each milestone will be in one location in Qualtrics. In this example, the people functional area description would include both hiring staff and establishing a committee. Supporting documentation would be submitted during milestone reporting for both of those activities.

Q: The implementation plan states: “Planning and implementation milestones for new interventions should be completed no later than PY3Q4 (Jul. – Sept. 2024)” and also “hospitals may complete planning and implementation milestones at any point prior to PY4Q2 (Jan. – Mar. 2025)”. If hospitals are, let’s say, not fully rolling out their intervention until December 2024, wouldn’t that mean they would have to report that during the next reporting period at the end of PY4Q2 (or March 2025) and then wouldn’t that be too late? Or is this just saying that hospitals are expected to be implementing their intervention by September 2024 but then can put some finishing touches on it in the three months after?

A: Planning and implementation milestones for new interventions must be completed by PY3Q4, which means the intervention should be fully operational and rolled out to the target population by September 31, 2024. Activities after this time should be directed to the completion of the continuous learning and improvement milestone to be completed by March 2025.

Q: Would be appropriate to have updating policies as our first milestone?

A: Yes, updating policies can qualify as the process functional area for a milestone.

Q: I am concerned my milestones aren't as definitive as they should be. Can we include activities such as "We will evaluate XYZ" or is that too vague?

A: That is acceptable. Make sure you address what your plan is and what you are trying to solve or do. For example, if you say you're going to investigate staffing needs for the intervention, the subsequent milestone should be that the staffing decisions were made. Make sure you follow through with your activities.

Q: If we were to put two activities under a particular quarter, would they be weighted equally (50/50) or would it be all or nothing in terms of the at risk dollars?

A: You may have multiple discreet activities for each milestone reporting period, but they are all categorized as one milestone per quarter and scored as such. If one activity of the milestone is not completed as planned, the milestone is not considered complete.

Q: Should we make a connection between barriers identified in section 3a of the implementation plan and the milestones defined in section 3b?

A: There isn't necessarily a requirement around this; however, if you have identified a major need for the intervention in section 3a, it would be a best practice to include satisfying that need as a milestone. For example, if you indicate that a technology platform will need to be developed or obtained to operate the intervention in section 3a of the implementation plan, it would be good to include that as a technology activity for one of your milestones.

Q: Is health equity required to be addressed in both the planning and implementation and continuous improvement milestone phases?

A: Health equity is required to be addressed in at least one continuous improvement milestone. Health equity is not required to be addressed in the planning and implementation phase, with the exception of the hospital index, which includes addressing health equity as one of the predefined required elements of the patient engagement functional area for the PY2Q2 milestone.

Q: The reference materials indicate that hospitals should address health equity by analyzing the intervention’s impact disaggregated by race, ethnicity, gender, and other demographic variables related to populations that experience health disparities. Are all demographics listed required or are those listed merely examples of what demographics a hospital can choose to address?

A: The demographics listed are examples; however, the hospitals should strive to address each demographic listed. If there are other demographics that are of particular focus for the community the hospital is serving, the hospital may alter the demographics analyzed accordingly to ensure health equity among the applicable community.

Planning and Implementation Milestones

Q: Does every functional area need to be addressed during each planning and implementation milestone reporting cycle?

A: Each milestone reporting cycle does not have to address every functional area. The only time every functional area must be addressed is when reporting the impact milestone indicating that the intervention is fully implemented.

Q: In one of the examples, PY2Q2 has people listed as the functional area. Does an intervention have to follow this example or can PY2Q2 for example include functional area people and process?

A: Any example released by the Department is strictly illustrative. The hospital can use any combination of functional areas for their planning and implementation milestones; it does not have to be people for PY2Q2. Impact milestones must address all four functional areas.

Q: Does an intervention need to have all the milestone functional areas addressed prior to the impact milestone? Or could you have an intervention have only the impact milestone (such as the index measure)?

A: All functional areas do not have to be addressed prior to the intervention being fully implemented (impact milestone). For example, if the hospital has addressed 3 of 4 functional areas, do not complete another planning and implementation milestone that just addresses the fourth functional area. Instead, the next milestone would be the impact milestone that addresses all four functional areas. Remember that impact milestones must occur no later than PY3Q2 for existing interventions.

Q: For one of the interventions, providers will need certification to deliver care, education, etc. Would that be classified as People or Process?

A: Activities to develop staff, such as obtaining certifications, should be classified as "people".

Q: Can I use the same or similar activities for planning and implementation milestones across multiple interventions?

A: The planning and implementation phase should be intervention specific. There are certain activities, like staff training, that will need to occur regardless of the intervention; however, the hospital should ensure their milestones reflect an intervention specific approach to implementation and that milestones listed are relevant to the applicable intervention.

Patient Engagement

Q: Please clarify how hospitals will engage patients in the hospital index with the use of Prometheus data.

A: Hospitals may refer to the hospital index guidance document. In general, hospitals need to consider which areas and which procedures codes have the highest impact on their hospital's index score. Hospital teams must then 1) determine what that information tells them about the patients being seen and 2) determine how these tools are being used to inform and impact clinical interventions or processes of care for patients in the future. Focus on how you are making sure there is a patient-centered approach for the patient engagement functional area.

Q: What sort of activities/documentation should we have for patient engagement? Results of patient surveys/focus groups etc.?

A: Yes, patient surveys and focus groups could meet the criteria. The hospital could also conduct a pilot where they roll out the intervention to a subset of the population to see what can be improved. Documentation in that case could be a narrative. Then, the impact milestone would be that the intervention was rolled out to all patients.

Q: Could developing patient engagement materials and bringing them to a patient and family advisory council (PFAC) for input and approval count as a "patient engagement functional area" milestone in the planning and implementation phase?

A: Yes. Further, if there is a rollout necessary, we do want to see that addressed in your patient engagement milestone

Q: How do we document that the intervention has been rolled out to patients?

A: Presentation to leadership that the intervention has been rolled out to patients could suffice as supporting documentation

Q: Is rolling out a patient facing education material considered "people" or "patient engagement"

A: Education material for patients would represent "patient engagement." Training patient navigators to support patients would represent "people."

Impact Milestones

Q: Can the impact milestone restate and confirm that a functional area was complete and addressed earlier in the implementation plan/ prior milestone report period?

A: If the hospital completes an activity in a prior period, even for the impact milestone reporting, the hospital should describe how the functional process is being maintained. The impact milestone can reference a prior period and provide a narrative update rather than repeating the same information. For example, if the technology build was completed in a prior quarter, state the date it was completed and explain how it has been implemented and maintained.

Q: Is the impact milestone equivalent to meeting all prior discrete milestones, or are we expected to meet brand new components - people, process, technology, and patient engagement/ target population activities again in the quarter in which the impact milestone is reported?

A: The impact milestone is not equivalent to the collection of all current and prior reporting of functional area components. During the quarter that an impact milestone must be reported, the hospital must briefly describe each of the functional areas and how a new activity was put in place, or how a prior activity is being maintained, for each.

Q: Which milestones need to be an impact milestone?

A: Impact milestones will occur once the intervention is fully operational. New interventions must have an impact milestone by PY4Q2. Existing interventions must have an impact milestone by PY3Q4. Hospital index intervention must have an impact milestone by PY2Q2.

Q: If I have an already developed measure, is the first milestone an impact milestone?

A: Yes, demonstrate that the intervention is fully operational via the impact milestone then move directly into continuous improvement milestones for that intervention.

Implementation Plan: Improvement Milestones

Q: Will hospitals be asked to speak to milestones again after hospitals are fully at scale?

A: Once a hospital is fully at scale, the hospital is in the continuous learning and improvement phase. Your hospital will need to briefly describe continuous learning and improvement activities for every milestone reporting period for the duration of the program.

Q: Does there need to be a continuous milestone for each quarter once impact milestone is reached as outlined in the “submission of proposed milestone”?

A: Milestones are reported only twice yearly, rather than quarterly. However, once you have completed the impact milestone (intervention is fully operational) and move into continuous improvement, you do need to have a continuous improvement milestone each milestone reporting period throughout the end of program year 5.

Q: How many continuous improvement milestones will we need to report?

A: This depends on when you anticipate completing the impact milestone. Every milestone reporting period after the impact milestone is completed must be a continuous improvement milestone through the end of the program.

Q: Can you discuss supporting documentation for continuous improvement milestones and what that might look like?

A: There may be some repetition (i.e., Plan-Do-Study-Act cycle). However, hospitals should be sure to add some differentiation. What did you do and what were the results each cycle? Include a report or evaluation summary. Focus on problem areas along with utilization.

Q: How detailed do we need to be in the continuous milestones. Understand that these will be focused around PDSA processes, but we do not know what will be the focus of those PDSA cycles until we have some baseline data. This is challenging to outline before the implementation plan is due.

A: How you structure your continuous learning and improvement milestones can be based on workflows, high level. Detailed information isn't required until achievement.

Q: What is the health equity requirement?

A: Hospitals must address health equity as part of their continuous learning and improvement milestones. At least one continuous learning and improvement milestone must address health equity. Hospitals should, at a minimum, analyze the intervention's impact disaggregated by race, ethnicity, gender, language, and other demographic variables related to populations that experience health disparities.

Q: Can I address health equity in the planning and implementation phase?

A: Yes; however, it is very important that distinct activities and their corresponding documentation are numbered to prevent confusion once the information is transferred from your template into Qualtrics. See Appendix A: Implementation Plan Numbering for example. Please note that this is purely for illustrational purposes. Hospitals are not required to list multiple activities per functional area in one quarter and are only required to describe one piece of supporting documentation per distinct activity.

Q: What kind of activities qualify as continuous improvement?

A: Continuous improvement milestones focus on incorporating continuous quality improvement practices into ongoing intervention operation. Activities that are part of the ongoing intervention should not be listed as a continuous improvement milestone.

Q: Can I use the same or similar activities for continuous improvement milestones across multiple interventions?

A: If the hospital's continuous improvement methodology is the same across multiple interventions, that is acceptable. However, the hospital should indicate that the continuous improvement process will be specific to the applicable intervention.

For example, instead of saying the hospital will complete a PDSA cycle and using the same verbiage for all interventions, specify that a PDSA cycle specific to the ALTO intervention will be conducted.

Supporting Documentation

Q: Can hospitals submit an attestation as supporting documentation confirming we are fully at scale?

A: An attestation will not be accepted. Supporting documentation should confirm the hospital is at scale based on policies, processes, staffing, etc. in place.

Q: When will hospitals supply supporting documentation?

A: The supporting documentation to be submitted will be established in the hospital's implementation plan. However, no documentation is required to be submitted with the implementation plan. Documentation will be due during the reporting cycle one month following Q2 and Q4 of the identified milestone completion date.

Q: How can hospitals predict what supporting documentation will be available to provide, given that a lot of these interventions are not in place currently?

A: Hospitals should consider the list of activities that need to be in place for the selected intervention. Consider what will indicate progress to your hospital governance committee. Documentation descriptions can be high-level, but should clearly explain how it will support the milestone's completion.

For example, for the 'people' functional area, the hospital plans on hiring people, transitioning staff from other areas, and developing training for those individuals. The hospital may not know who the staff will be or what the training will entail, but they can list that supporting documentation will include a staffing list, the training slides, and training attendance records. The documentation should be specific to the milestone.

Q: HCPF has indicated documentation cannot include PHI. How else can I demonstrate proof?

A: If applicable supporting documentation for a particular milestone contains PHI, the hospital may submit a redacted copy.

Q: Regarding supporting documentation for milestones, the examples given from HCPF have multiple documents for each functional area listed as supporting documentation. I was planning on submitting one document/screenshot/other materials per functional area. Is that ok?

A: Any example provided by the Department is solely illustrative. The amount of supporting documentation depends on the milestone. For example, if the People milestone is to hire and train, those are two discreet actions that will be accomplished. Submission of training curriculum would be one type of supporting documentation, but that doesn't document hiring. Therefore, separate documentation would be required for hiring.

Q: We don't know how we will be communicating with the RAE. How will we submit supporting documentation since we don't know what the process will be?

A: The specifics do not have to be defined now. Provide the high level process of what needs to be developed. Detail will come later when the documentation is actually submitted. Supporting documentation does not actually need to be submitted with the implementation plan. Documentation will be submitted during quarterly reporting. The implementation plan just describes what the documentation will be.

Q: For supporting documentation, can our documentation description be simply a screenshot of a report?

A: A blank copy of the report and details of how that report will be developed would be sufficient. A screenshot without PHI could fall into that category.

Q: Can we say "Evidence of completed PDSA cycle" as our expected supporting documentation for the continuous improvement milestones?

A: Yes; however, we recommend you include high level summaries and findings. Ideally, you'll discuss the actual activities or steps that were taken.

Q: Can I use meeting minutes as supporting documentation?

A: While meeting minutes will suffice, hospitals should clearly indicate how the completion of the activity will be supported in the meeting minutes. For example, if the milestone is “receive approval from the RAEs to send the notifications according to the developed process”, the supporting documentation description should specify who the meeting is with (in general terms) and what information that supports the activity's completion will be included. To illustrate, instead of simply listing "meeting minutes", the hospital could list "RAE meeting minutes that specify the RAE’s approval of the notification process."

Hospital Index

Q: Qualtrics indicates certain responses should be less than 2000 characters. However, some of the predefined elements for the hospital index require lengthy responses. How can we address all required elements and keep the response under 2000 characters?

A: For the hospital index milestones, you will complete those just as you are for other interventions. The first milestone will be the impact milestone for that intervention. For the implementation plan, we just need to know the continuous learning and improvement intervention you are going to put into place utilizing the hospital index tool. Within that you should state how that intervention will also answer the pieces indicated in the milestone guidance document. We do not need any of the answers to those items in the milestone

guidance document at this time. You will provide that detail at the appropriate milestone interval as indicated in the guidance document.

Q: Is it true that stakeholder assessment is the group you are working with in order to identify episodes? And we will have discussion among them to see what is driving those episodes?

A: Correct - stakeholders must be engaged for quality improvement of the hospital index intervention.

Q: The hospital index questions ask us to describe the next reporting cycle, even though that will not have happened yet. Can you clarify?

A: There is a difference between what is documented for the implementation plan and what documentation you will have to eventually provide for the quarterly reporting period. You are not going to know exactly what the answers are at this time for inclusion in the implementation plan, but you can document that you will be providing those answers. The expectation is that you will be able to answer those questions when it is time to report on the milestone.

Appendix A: Implementation Plan Numbering

Implementation Plan Template: Multiple activities per functional area per milestone reporting period.

Section III.B: Intervention Milestones							
Performance Period	**Completion Date**	**Milestone Code**	**Milestone Phase**	**Functional Area**	**Functional Area Description / Milestone Description**	**Supporting Documentation**	**Impact Milestone (Y/N)**
Note: Add rows where needed to address multiple functional areas within a single performance period, such as the Impact Milestone and other Planning and Implementation phase milestones (see Example tab).							
PY2Q2	3/31/2023	INT1.PY2Q2	Planning and Implementation	People	1. Key hospital leadership identified and engaged to support necessary steps in SBIRT implementation	1. Letter of commitment to SBIRT implementation from hospital executive leadership team.	N
PY2Q2	3/31/2023	INT1.PY2Q2	Planning and Implementation	People	2. Develop training materials and schedule	2. Copy of training material and schedule.	N
PY2Q2	3/31/2023	INT1.PY2Q2	Planning and Implementation	Process	1. Completed organizational self-assessment for SBIRT implementation readiness with the SBIRT project team	1. Completed self-assessment worksheet.	N
PY2Q2	3/31/2023	INT1.PY2Q2	Planning and Implementation	Process	2. With staff feedback, project team decided on a validated screening tool to utilize	2a. Copy of meeting minutes 2b. Presentation discussing screening tools 2c. Copy of chosen screening tool	N

Qualtrics Survey: Multiple activities per functional area per milestone reporting period.

People Functional Area

Please include a brief description of the People Functional Area for this milestone (no more than two sentences).

Functional Area Description Definition - A short description of the actions that will constitute the completion of the milestone.

1. Key hospital leadership identified and engaged to support necessary steps in SBIRT implementation
2. Develop training materials and schedule

Please describe the supporting documentation which will be provided in support of the Functional Area for this milestone (no more than two sentences).

Supporting Documentation Definition - The name and a brief description of the materials that will be submitted as evidence of the milestone's completion.

1. Letter of commitment to SBIRT implementation from hospital executive leadership team.
2. Copy of training material and schedule.

Process Functional Area

Please include a brief description of the Process Functional Area for this milestone (no more than two sentences).

Functional Area Description Definition - A short description of the actions that will constitute the completion of the milestone.

1. Completed organizational self-assessment for SBIRT implementation readiness with the SBIRT project team
2. With staff feedback, project team decided on a validated screening tool to utilize

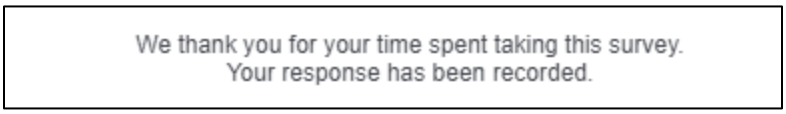
Please describe the supporting documentation which will be provided in support of the Functional Area for this milestone (no more than two sentences).

Supporting Documentation Definition - The name and a brief description of the materials that will be submitted as evidence of the milestone's completion.

1. Completed self-assessment worksheet.
2a. Copy of meeting minutes
2b. Presentation discussing screening tools
2c. Copy of chosen screening tool

Appendix B: Generate PDF of Responses Instructions

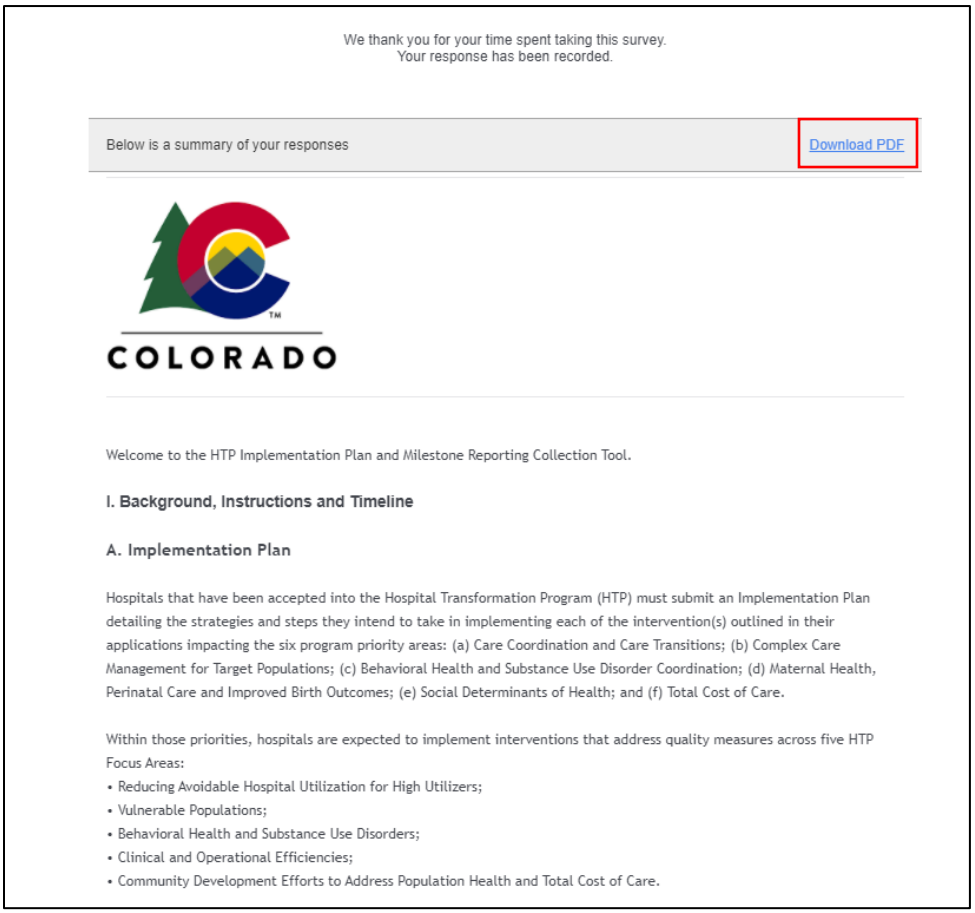
1. Upon hitting “Submit” to officially log your hospital’s response, you will be redirected to a page that confirms your hospital’s submission has been logged in our survey platform. All hospitals will be able to be see this message:



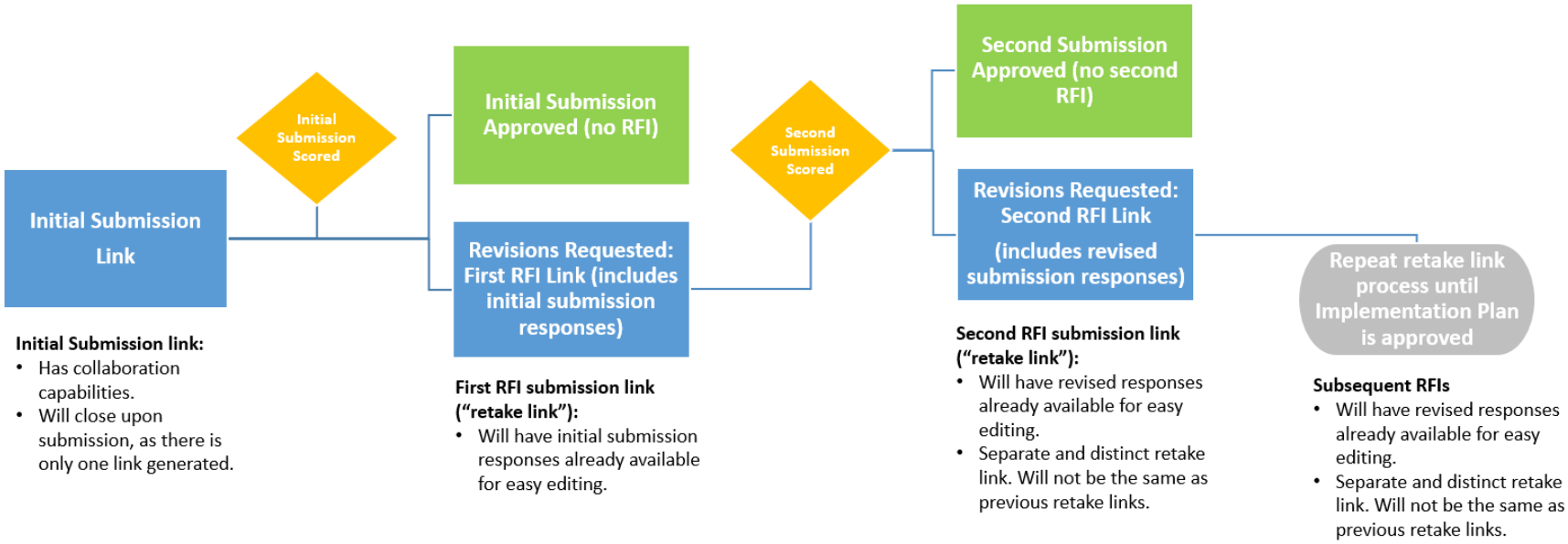
2. As a newly added feature, hospitals will be able to review the responses submitted as well as download a pdf of responses logged. (If you had opened up the link prior to our team pushing out this function, you may not be able to see the review page.)

3. You may then scroll through the page to review your responses. If you would like, you may also click on the link to “Download PDF” of your hospital’s responses.

As this is a one-time review page, you will not be able to access your responses and download after clicking off the confirmation page. Please be sure to download the PDF if this is something your team will need for your records.



Appendix C: Retake Link Flow Chart



Initial Submission link:
- Has collaboration capabilities.
- Will close upon submission, as there is only one link generated.

First RFI submission link ("retake link"):
- Will have initial submission responses already available for easy editing.

Second RFI submission link ("retake link"):
- Will have revised responses already available for easy editing.
- Separate and distinct retake link. Will not be the same as previous retake links.

Subsequent RFIs
- Will have revised responses already available for easy editing.
- Separate and distinct retake link. Will not be the same as previous retake links.

Retake Links
- No longer have collaboration capabilities. We recommend hospitals delegate one person to record responses in the survey link at this time.
- Will have save and continue functions, as long as it taken on one computer and browser.
- New records will be generated every time the link is clicked on a new computer. Those records do not "talk" with each other. Only responses that are actually submitted will be recorded and captured for MSLC review. Please ensure only one response is submitted.