Colorado Hospital Transformation Program

Implementation Plan Template and Milestone Requirements

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CHASE
Colorado Healthcare Affordability and Sustainability Enterprise

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I. Background, Instructions and Timeline

A. Implementation Plan

Hospitals that have been accepted into the Hospital Transformation Program (HTP) must submit an Implementation Plan detailing the strategies and steps they intend to take in implementing each of the intervention(s) outlined in their applications impacting the six program priority areas: (a) Care Coordination and Care Transitions; (b) Complex Care Management for Target Populations; (c) Behavioral Health and Substance Use Disorder Coordination; (d) Maternal Health, Perinatal Care and Improved Birth Outcomes; (e) Social Determinants of Health; and (f) Total Cost of Care.

Within those priorities, hospitals are expected to implement interventions that address quality measures across five HTP Focus Areas:

- Reducing Avoidable Hospital Utilization;
- Core Populations;
- Behavioral Health and Substance Use Disorder Coordination;
- Clinical and Operational Efficiencies;
- Population Health and Total Cost of Care.

Section II of the Implementation Plan will include the hospital's proposed organizational approach to implementation. Section III will include the approach to implementation of each intervention approved for participation via the Hospital Application. Hospitals must complete Section III for each intervention.

Implementation Plans cover the five-year duration of the HTP. Hospitals will have an opportunity to revisit their planned milestones and if needed, submit milestone amendments and course corrections through the quarterly reporting process. The process for amending milestones and for course correction is outlined in the HTP Milestones Requirements section of this document.

B. Implementation Plan Process and Timeline

Implementation Plans must be submitted during the Implementation Submission Period (from September 1, 2021 through September 30, 2021) after approval of the hospital's HTP application. Hospitals will submit their Implementation Plans in the online submission tool. The entirety of the Implementation Plan has been recreated in the Implementation Plan submission tool for hospitals to complete and submit by 11:59 pm on September 30, 2021. Certain elements of information will be pre-populated in the Implementation Plan submission tool from the approved HTP Application. HTP primary contacts will be emailed a unique link to the submission tool where they will be able to complete their Implementation Plan. The

email with the link to the submission tool will also be made available in the HTP Colorado Collaboration, Performance, and Analytics System (CPAS) portal.

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.

- **September 1 –** First day Implementation Plans may be submitted
- **1 month time period / September 1 – September 30** - Implementation Plan Submission Period (Implementation Plan Deadline: September 30)
- **20 business day period / October 1 – October 28** – Review Period: Twenty business day Department review period
- **10 business day period / October 29 – November 12** - Revise and resubmit period: Ten business day period within which any plan requiring additional revisions and / or supporting details should be completed by hospital
- **10 business day period / November 15 – November 29** – Final Review Period: Ten business day scoring period for revised and resubmitted Implementation Plans
- **2 months following due date/November 30** – Expected final Implementation Plans approved

All hospital final implementation plans will be made public and posted online enabling stakeholders to review how their hospitals plan to achieve the goals of the Hospital Transformation Program.

C. Implementation Plan Scoring

Implementation Plans collect the hospital approach on the *Organizational Approach to Implementation* and the *Approach to Intervention Implementation*. The *Approach to Intervention Implementation* must be completed for each of the hospital's interventions. Except for questions that are prepopulated from the Hospital Application, responses will be scored on either a pass / fail or a numerical basis as outlined below.

Pass / fail scores will be based on the following:

- Fail: The response is incomplete because it does not address one or more parts of the question asked. More information must be provided for the answer to be considered complete.
- Pass: A complete response was provided to all applicable aspects of the question.

Implementation Plans must earn passing scores for every pass / fail response to be approved. Any question receiving a failing score during the review period will be returned to the participant with specific instructions for revisions prior to resubmission.

Numerical scores will be based on a one to three (1-3) scoring rubric.

- A score of one (1) will be given to answers that need substantial revision. Scores of one indicate that responses are either incomplete (do not address one or more part(s) of the question asked) or do not demonstrate a satisfactory approach. Examples of responses that would not demonstrate a satisfactory approach include:
    - ✓ A response to Question III.A.6. that does not include a plan for identifying and engaging the intervention's target population including addressing barriers to recruitment and resulting gaps in engagement.
    - ✓ A response to Question III.A.7. that does not describe the resources that will need to be re-purposed from other areas, built, acquired, or secured through a partner or in some way.
    - ✓ A response that describes supporting documentation for an impact milestone that is insufficient to validate its completion.
- A score of two (2) represents a generally complete and satisfactory response to the question (criteria for scores of one outlined above do not apply) with only limited clarification or additional information needed to ensure responses are detailed enough to provide the Department with a complete and accurate understanding of the response. Any additional information or clarification needed will be specifically cited by the Department.
- A score of three (3) represents a complete, sufficiently detailed and acceptable response and approach to the topic addressed (criteria for scores of one and two outlined above do not apply).

Participants must earn scores of three (3) for every response included in their Implementation Plan for it to be approved. Any question receiving a one (1) or two (2) during the initial Implementation Plan review period will be returned to the hospital with specific instructions for revision prior to resubmission. The Department will provide technical assistance aimed at ensuring Implementation Plans receive approval.

The tables below summarize the questions in the Implementation Plan and the applicable scoring. Questions that will be prepopulated in the Implementation Plan submission tool from the Hospital Application will not be scored and are marked as "prepopulated" in the scoring column of the tables below.

Table 1: Organizational Approach to Implementation

Section II Implementation Overview

Component	Question	Scoring
Points of Contact	II.A.1.a. II.A.1.b.	Pass / Fail
Role of Governance Structure	II.A.2.	Pass / Fail

Table 2 Approach to Intervention Implementation

Section III.A Overview of Intervention

Component	Question	Scoring
Reporting Hospital	III.A.1.	Prepopulated
Name of Intervention	III.A.2.	Prepopulated
Primary Quality Measure(s)	III.A.3.	Prepopulated
Identification of Existing Interventions	III.A.4.	Pass / Fail
Principal Administrative Roles	III.A.5.	Pass / Fail
Target Population	III.A.6.	1 – 3
Major Functions and Resources	III.A.7.	1 - 3
Challenges and Risks	III.A.8.	1 - 3
Ongoing CHNE	III.A.9.	Pass / Fail

Section III.B Intervention Milestones

Component	Question	Scoring
Milestones	III.B.1. III.B.2. III.B.3.	1 - 3

II. Organizational Approach to Implementation

This section contains the prompts HTP participants will respond to within the Implementation Plan submission tool that relate to the hospital's organizational approach to implementation.

A. Implementation Overview

II.A.1.a. Please fill out the following information for the hospital's primary contact.

Primary Contact Name: _____
Primary Contact Title: _____
Primary Contact Address: _____
Primary Contact Phone Number: _____
Primary Contact Email Address: _____

II.A.1.b. Please fill out the following information for the hospital's secondary contact.

Secondary Contact Name: _____
Secondary Contact Title: _____
Secondary Contact Address: _____
Secondary Contact Phone Number: _____
Secondary Contact Email Address: _____

II.A.2. Governance Structure - Describe how the governance structure outlined in response to Question 3 of the HTP Application will be engaged in the implementation and execution of the hospital's HTP participation. Address how leadership will ensure oversight and support, including sign off/approval for resources, and address their role in the following functional areas, as applicable:

- People (Workforce / Training)
- Processes of Care
- Technology and Data Systems
- Patient Engagement / Target Population

Please seek to limit response to 1,000 words.

III. Approach to Intervention Implementation

Hospitals must complete this section in the Implementation Plan submission tool separately for each of the interventions (or statewide priority) approved for inclusion in the HTP.

A. Overview of Intervention

III.A.1.	Reporting Hospital	WILL BE PREPOPULATED FROM APPLICATION
III.A.2.	Name of Intervention	WILL BE PREPOPULATED FROM APPLICATION
III.A.3.	Primary Measure(s):	WILL BE PREPOPULATED FROM APPLICATION

III.A.4. Is this an existing intervention (an intervention that the hospital previously planned and is currently implementing or executing)? (See definition in the HTP Milestones Requirements section of this document.)

☐ Yes

☐ No

III.A.5. The below chart is for principal internal and external administrative roles for this intervention. If there are more than five individuals working on this intervention, please list the five individuals with the greatest leadership roles or most time dedicated to this intervention.

Name of Individual	Intervention-Specific Role	Role will lead implementation of the intervention (Y/N)	Name of Organization	Key Deliverables / Responsibilities

III.A.6.a. Briefly describe the intervention's target population for the intervention. This should align with the hospital's approved HTP Application. (Please respond in no more than two sentences.)

III.A.6.b. Describe how individuals within the target population will be identified and engaged in the intervention. (Please seek to limit response to 500 words.)

III.A.7.a. Describe what major functions and resources, supporting the initiative throughout the course of implementation 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.

Please address the following functional areas and resources, at a minimum, when responding[1]:

- People (Workforce / Training)
- Processes of Care
- Technology and Data Systems
- Patient Engagement / Target Population

III.A.7.b. Use the following space to describe the major functions and resources that are already in place. (Please seek to limit response to 1,000 words.)

III.A.7.c. Use the following space to describe the major functions and resources that 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. (Please seek to limit response to 1,000 words.)

III.A.8.a. Describe any major challenges and risks to intervention implementation and how the hospital will mitigate those challenges and risks. In the response, specifically address the following areas:

- Workforce;
- Budget;
- Health Information Technology;
- Regulatory Barriers; and
- Challenges related to engaging difficult-to-reach populations.

III.A.8.b. Use the following space to describe any major challenges and risks to intervention implementation. (Please seek to limit response to 750 words.)

III.A.8.c. Use the following space to describe how the hospital will mitigate the challenges and risks described above. (Please seek to limit response to 750 words.)

[1] See section IV. Milestone Requirements, for more detailed definitions of each functional area.

III.A.9. Describe how this intervention will benefit from the hospital's ongoing Community and Health Neighborhood Engagement efforts. (Please seek to limit response to 500 words.)

B. Intervention Milestones

Hospitals must propose and record in the Implementation Plan submission tool one milestone in both Quarters 2 and 4 (Q2 and Q4) for each Program Year (PY) starting with PY2Q2 (Jan. – Mar. 2023). Milestones should be discrete tasks that, when completed, have an easily identifiable, quantifiable, and definable goal that has been reached or action that has been completed. The milestones established must be completed by the end of the quarter for which the milestone is applicable (Q2 or Q4).

All milestones should be associated with their applicable phase: *Planning and Implementation* or *Continuous Improvement*. Distinct milestone requirements apply to each phase, and timing of the phases depends on whether the intervention is new or existing. Planning and Implementation milestones should be completed no later than PY3Q4 (Jul.- Sept. 2024) and Continuous Improvement milestones should begin no later than PY4Q2 (Jan. – Mar. 2025), with accelerated milestones for existing interventions subject to the timeline outlined in this document. Hospitals may complete Planning and Implementation milestones at any point prior to PY4Q2 and begin reporting Continuous Improvement milestones. Additionally, unique considerations apply for the Hospital Index Measure, as outlined in the Milestones Requirements section of this document.

The submission tool will guide hospitals through recording milestones per intervention for each applicable program year quarter. Hospitals will indicate the milestone phase and whether it is an impact milestone. Interventions will be prepopulated in the submission tool based on the hospital's approved HTP Application.

III.B.1. Please answer the following questions with information related to this intervention's milestone.

What phase does this milestone fall under?

- ☐ Planning and Implementation
- ☐ Continuous Improvement

III.B.2. Is this the impact milestone for this intervention?

The final milestone of the Planning and Intervention phase should be an impact milestone. If this is the impact milestone for this intervention, please keep in mind:

- The impact milestone should address all functional areas applicable to the intervention.
- The impact milestone functional area descriptions and supporting documentation should demonstrate that the intervention has been fully implemented.

☐ Yes

☐ No

III.B.3.a. Please indicate which Functional Area(s) applies to this milestone. Select all that apply. Impact milestones must include all Functional Areas.

☐ People

☐ Process

☐ Technology

☐ Patient Engagement/Target Population

For each applicable Functional Area, indicate the following:

III.B.3.b. Please include a brief description of the [*People, Process, Technology, Patent Engagement / Target Population*] 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.

For each applicable Functional Area, indicate the following:

III.B.3.c. 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.

IV. Milestone Requirements

A. Overview

Beginning in Program Year (PY) 2 (Oct. 2022 – Sept. 2023) of the Hospital Transformation Program (HTP), participating hospitals can earn at-risk dollars under the HTP through completion and reporting on intervention milestones.

"**Milestones**" are defined as key activities or deliverables that reflect successful completion of key steps toward the participant's intervention and subsequent achievement of HTP goals. Milestones should be important to the hospital's overall development process. Milestones should be discrete tasks that, when completed, have an easily identifiable, quantifiable, and definable goal that has been reached or action that has been completed. Each milestone, when completed, will require the submission of the supporting documentation described in the Implementation Plan and will be used by the Department to validate whether the milestone has been successfully completed.

Interventions and their accompanying milestones should be developed with an anticipated date of reaching their full scale or near-to-full scale levels of impact by the conclusion of PY3 (Oct. 2023 – Sept. 2024). This will be demonstrated by the inclusion (and achievement) of an impact milestone as the final milestone for the Planning and Implementation phase as outlined below. HTP participants applying to use an existing intervention should submit milestones at the same level of definition as those entities that are applying to use new interventions, but those milestones must be proposed at an accelerated timeline as outlined below.

Starting in PY1 (Oct. 2021 – Sept. 2022), participating hospitals will be required to submit quarterly reports that address progress on milestones and associated interim activities related to each HTP intervention's progress. Milestones will be reported and at-risk dollars evaluated semi-annually, with associated "interim activities" reported in the intervening quarters.

"**Interim activities**" should track progress towards intervention milestones. Payment is not specifically tied to the successful completion of interim activities. However, interim activity progress toward completion of milestones must be reported and the Department will use interim activities to understand overall implementation progress.

As transformation activities are inherently dynamic, the HTP will allow each participant to submit proposed milestone amendments along with their HTP reports for Q2 and Q4. Each amended milestone will need to be submitted along with justification for the change. Hospitals will also have opportunities for course corrections as outlined in further detail below.

B. Milestone Requirements

The HTP is built around three primary phases for measuring progress. Milestones should be developed and submitted under phases one and three below (phase two is comprised only of performance metrics):

1. **"Planning and Implementation Phase"**: These milestones should document the process through which the participant will complete all necessary preliminary activities (e.g. preparation, gap assessments) that support implementation. The final set of this phase's milestones should focus on implementation activities resulting in the intervention's inception.

2. **"Performance Phase"**: The performance phase is comprised of all performance measures that will begin determining, in part, participating hospital payments of at-risk dollars beginning in PY3 (Oct. 2023 – Sept. 2024).

3. **"Continuous Improvement Phase"**: This second phase of milestones must focus on how the participant is incorporating continuous quality improvement practices into the intervention's ongoing operation. These milestones could include documented 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.

Each milestone occurring during the Planning and Implementation phase must also be identified as affecting one or more of the following **"Functional Areas."**:

- People: These milestones could include activities related to workforce development, including training new or existing staff members, redeploying staff members into materially new roles or identifying key project personnel.
- Process: These milestones include activities related to a material shift in how clinical processes (e.g. patient hand-offs, post discharge follow-ups) will be completed as a result of the proposed intervention.
- Technology: These milestones apply to the updating, acquisition or repurposing of underlying electronic health data storage, use or exchange either within or across the HTP participant's primary service units or with the state's health information exchange (CORHIO).
- Patient Engagement / Target Population: These milestones include the identification and enrollment of patients that fall within target populations. Patient Engagement milestones should be included for all interventions and must include quantifiable impact milestones relative to progress toward reaching full engagement of the target population as outlined in more detail below.

The final milestone for each intervention's Planning and Implementation phase shall be an "impact milestone" that demonstrates that the intervention has been fully implemented. The

impact milestone should address all functional areas (if one or more functional areas are not applicable to the intervention, the hospital should demonstrate that).

For example, if the intervention is based on increasing Social Needs screeners where the target population is all inpatient admission patients, impact milestone supporting documentation could include:

- People: The total number of individuals trained to properly administer the screener and assigned to screen;
- Process: The policies and protocols for implementing and administering the new screener;
- Technology: A screenshot of the system that has been implemented or updated to accept screener data;
- Patient Engagement / Target Population: Aggregated, de-identified thirty day results of health screener for all patients in the inpatient setting.

The achievement of the final Planning and Implementation milestone will be dependent on the milestone's activities being successfully completed and will indicate the conclusion of the Planning and Implementation phase for that intervention. All future milestones should be designated as Continuous Improvement phase milestones.

Planning and Implementation milestones for new interventions should be completed no later than PY3Q4 (Jul. – Sept. 2024) and Continuous Improvement milestones should begin no later than PY4Q2 (Jan. – Mar. 2025). However, hospitals may complete Planning and Implementation milestones at any point prior to PY4Q2 (Jan. – Mar. 2025) and begin reporting Continuous Improvement milestones.

For existing interventions, it is expected that hospitals will reach their full scale at an accelerated pace. "Existing interventions" are those interventions the hospital had implemented or was implementing on the day it submitted the HTP Application. The hospital may propose planning milestones specific to the enhancement of the intervention to meet HTP requirements (including impact milestones) and implementation milestones. However, final Planning and Implementation phase milestones for existing interventions must occur no later than PY3Q2 (Jan. – March. 2024). Similarly, the hospital should propose Continuous Improvement milestones to begin no later than PY3Q4 (July – Sept. 2024). Hospitals proposing to leverage existing interventions that are already at full scale at the beginning of the HTP should include an impact milestone as the first and only Planning and Implementation milestone for such interventions prior to moving on to Continuous Improvement milestones.

The tables below map the Implementation Plan milestone inputs expected for the course of the program, depending on whether the intervention is new, existing, or relates to the Hospital Index Measure.

Submission of Proposed Milestones (New)

Phase	Q	PY2 (Oct. 2022 – Sept. 2023)	PY3 (Oct. 2023 – Sept. 2024)	PY4 (Oct. 2024 – Sept. 2025)	PY5 (Oct. 2025 – Sept. 2026)
Planning and Implementation Phase Milestones	Q2	Impact Milestone: Y/N; Milestone Functional Area(s) and Description	Impact Milestone: Y/N; Milestone Functional Area(s) and Description	N/A	N/A
Planning and Implementation Phase Milestones	Q4	Impact Milestone: Y/N; Milestone Functional Area(s) and Description	Impact Milestone: Y/N; Milestone Functional Areas and Description	N/A	N/A
Continuous Improvement Phase Milestones	Q2	N/A	N/A	Milestone Description	Milestone Description
Continuous Improvement Phase Milestones	Q4	N/A	N/A	Milestone Description	Milestone Description

Impact Milestones for New interventions must be completed by the end of PY3 (Sept. 2024) and must address all Functional Areas. Continuous Improvement Phase Milestones must begin no later than PY4Q2 (Jan. – Mar. 2025).

Submission of Proposed Milestones (Existing)

Phase	Q	PY2 (Oct. 2022 – Sept. 2023)	PY3 (Oct. 2023 – Sept. 2024)	PY4 (Oct. 2024 – Sept. 2025)	PY5 (Oct. 2025 – Sept. 2026)
Planning and Implementation Phase Milestones	Q2	Impact Milestone: Y/N; Milestone Functional Area(s) and Descriptions	Impact Milestone: Y/N; Milestone Functional Areas and Descriptions	N/A	N/A
Planning and Implementation Phase Milestones	Q4	Impact Milestone: Y/N; Milestone Functional Area(s) and Descriptions	N/A	N/A	N/A
Continuous Improvement Phase Milestones	Q2	N/A	N/A	Milestone Description	Milestone Description
Continuous Improvement Phase Milestones	Q4	N/A	Milestone Description	Milestone Description	Milestone Description

Impact Milestones for existing interventions must occur prior to PY3Q4 (Jul. – Sept. 2024). Continuous Improvement milestones must begin prior to PY4 (Oct. 2024 – Sept. 2025).

Submission of Proposed Milestones (Hospital Index Measure)

Phase	Q	PY2 (Oct. 2022 – Sept. 2023)	PY3 (Oct. 2023 – Sept. 2024)	PY4 (Oct. 2024 – Sept. 2025)	PY5 (Oct. 2025 – Sept. 2026)
Planning and Implementation Phase Milestones	Q2	Impact Milestone	N/A	N/A	N/A
Continuous Improvement Phase Milestones	Q2	N/A	Milestone Description; Continuous Improvement Activities, Impact and Reporting	Milestone Description; Continuous Improvement Activities, Impact and Reporting	Milestone Description; Continuous Improvement Activities, Impact and Reporting
Continuous Improvement Phase Milestones	Q4	Milestone Description; Current State Assessment; Stakeholder Assessment; Continuous Improvement Activities, Impact and Reporting	Milestone Description; Current State Assessment; Continuous Improvement Activities, Impact and Reporting	Milestone Description; Current State Assessment; Continuous Improvement Activities, Impact and Reporting	Milestone Description; Current State Assessment; Continuous Improvement Activities, Impact and Reporting

Under the Hospital Index Measure, hospitals only complete one impact milestone, during PY2Q2 (Jan. – Mar. 2023). Continuous Improvement milestones begin PY2Q4 (Jul. – Sept. 2023) and continue for the remainder of the program. Please reference Appendix A of this document for additional guidance and clarification around the Hospital Index Measure.

C. Milestone Development and Review Process

HTP participants are required to create milestones that demonstrate progress toward intervention goals. When proposing milestones, hospitals must list the supporting documentation it plans to submit for each milestone. For Planning and Implementation milestones, supporting documentation must be submitted specific to each applicable functional area.

"**Supporting documentation**" should unambiguously demonstrate the reported status of the milestone. Participants are urged to define and submit supporting documentation that:

- Indicates it was completed in a timely manner (e.g. agendas from meetings that occurred within the timeframe of the milestone);
- Substantiates that the milestone was completed (e.g. submission of a gap assessment that was developed in pursuing a milestone calling for the development of a gap assessment).

When milestones are created and submitted in Implementation Plans, the Department will evaluate each to validate its appropriateness for the HTP participant's intended intervention goals. The Department will review and approve or request revision to all submitted milestones based on the following criteria:

1. Does the milestone constitute a necessary step in completing implementation activities for the submitted intervention?
2. Does the milestone include a description or functional area description(s) that is / are sufficient to define what constitutes completion?
3. Does the milestone include a description of the supporting documentation that will be used to validate completion and is that documentation sufficient to prove the milestone's completion?
4. Is the milestone appropriately categorized under one of the two applicable developmental phases (Planning and Implementation or Continuous Improvement)?
5. Are Planning and Implementation milestones properly identified under one or more of the four functional areas (people, process, technology, patient engagement / target population)?
6. Are milestones scheduled for completion in either Q2 or Q4, with at least two proposed for completion for each program year between PY2-PY5 (Oct. 2022 – Sept. 2026)?
7. Does the final Planning and Implementation milestone include an impact milestone as defined above with all four functional areas addressed?

When the Department completes its evaluation of submitted milestones as part of the Implementation Plan review, it will score based on the one to three (1-3) scoring rubric and may offer suggested revisions. Hospitals will have an opportunity to accept the milestone revisions if present or propose a new milestone.

D. Ongoing Program Reporting of Milestones and Validation Process

Quarterly reports will be submitted within 20 business days following the end of the reporting quarter. All reports will be reviewed by the Department for progress and completion of the milestones identified in the HTP participant's approved Implementation Plan.

All quarterly reports will be evaluated based on, but not limited to, the following criteria:

- Was the report submitted on time?

For Q1 and Q3 reports on interim activities:

- Was at least one interim activity linked to the milestone that will be submitted in the immediately subsequent quarter reported?

For Q2 and Q4 reports on milestone completion:

- Was the milestone completed by the end of the applicable quarter (Q2 or Q4)?
- Was the supporting documentation submitted for the milestone sufficient to validate its completion?

The Department will validate the quarterly reports to determine at-risk funds earned for reporting each quarter. For the milestone completion reports submitted for Q2 and Q4, the Department will also determine at-risk funds earned for milestone completion. The schedule below outlines the quarterly reporting validation process.

Validation Process Activity	Completion Date
Department begins review of all submitted quarterly reports	Report submission due date + 1 business day
Department reviews all supporting documentation (milestones) / responses regarding interim activities	Report submission due date + 15 business days
Department initial review of quarterly report complete	Report submission due date + 20 business days
Department notifies participant that scores received for quarterly reporting are available on CPAS portal	Report submission due date + 21 business days
Requests for reconsideration of scoring decisions due	Report submission due date + 31 business days
Department issues final scores for quarterly reports	Report submission due date + 45 business days

E. Milestone Amendments

Throughout the HTP, various factors may require a participant to shift its implementation strategies. New evidence-based models may emerge, or other key developments or operating characteristics of facilities may shift, requiring an amended approach to intervention completion. To allow for the flexibility to address unexpected barriers or outcomes, adopt new approaches and pursue innovative and emerging models of care, participants will be provided milestone amendment periods. This amendment process will occur as part of the reports for the second and fourth quarter of each program year. Note that only milestones due in future quarters may be amended.

To amend a single or multiple milestone(s), participants must record proposed milestone amendments along with reports for Q2 and / or Q4 that adequately address the following conditions for any proposed amended milestone:

- Milestone(s) for proposed amendment are clearly identified;
- Documentation to validate milestone completion is specified;
- Justification for amending the milestone(s) is provided;
- All the requirements outlined above regarding the development and submission of initial milestones have been satisfactorily met.

Following the submission of amended milestones, the Department will initiate a review and approval process in parallel with quarterly report filing review timelines:

Milestone Amendment Activity	Completion Date
Department begins review of amended milestone(s)	Q2 or Q4 Report submission due date + 1 business day
Department reviews milestone amendment(s) for sufficient justification and completed milestone requirements	Q2 or Q4 Report submission due date + 15 business days
Department completes review of proposed milestone amendment(s)	Q2 or Q4 Report submission due date + 20 business days
Department notifies participant of approval, approval with modifications or rejection of proposed milestone amendment(s)	Q2 or Q4 Report submission due date + 21 business days
Participant accepts Department's approval, approval with modifications or rejection of proposed milestone amendment(s) OR requests to resubmit and submits an updated milestone amendment(s)	Q2 or Q4 Report submission due date + 31 business days
Department issues final approval /denial of amended milestone(s). If approved, amended milestone(s) become part of the participant's Implementation Plan.	Q2 or Q4 Report submission due date + 45 business days

F. Intervention Course Correction

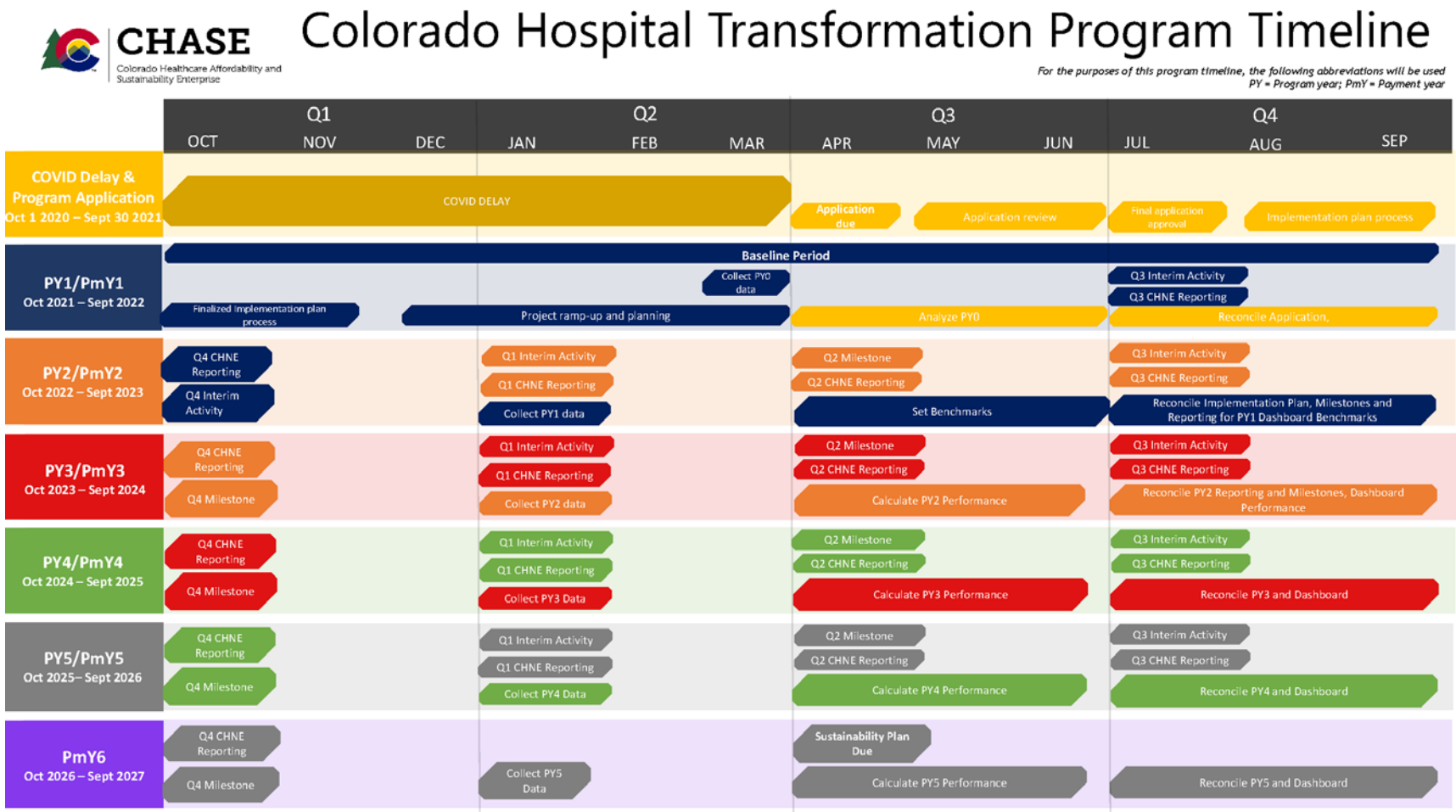
If a milestone is not completed, a portion of at-risk payments will be withheld. Hospitals subject to loss of at-risk dollars for missed (not completed) milestones may submit a course correction plan with the report for the quarter during which the milestone was missed (e.g. if a Q4 milestone was not completed, the course correction plan should be submitted with the report for that quarter). If the Department notifies the hospital that it has determined the hospital missed a milestone based on its review of the hospital's report (i.e. the hospital did not report missing the milestone), a course correction plan may be submitted 30 days after the final determination by the Department that the milestone was missed. 50% of all lost at-risk dollars may be earned back by submitting a course correction plan. Hospitals may submit a course correction plan once per intervention.

"**Course correction plans**" must provide insights into the root causes of a missed milestone and detail the process the program participant intends to pursue to either complete the missed milestone as previously defined or provide insight as to why the missed milestone will not or should not be completed. Course correction plans must also provide operational insights into how future milestones associated with the intervention will be completed by their previously intended deadlines. Part of the hospitals' plan for correcting an intervention's course may involve amending future milestones. While the course correction plan could discuss amending future milestones as part of the way forward, the course correction plan is not the mechanism by which milestones are amended. All milestone amendments must be submitted as an official milestone amendment, as discussed in the previous section of this document. As a result, if a course correction plan discusses milestone amendments which are not separately submitted as milestone amendments, no changes to the hospital's milestones will be recognized. As a reminder, as outlined above, milestones may also be amended prospectively through reports for Q2 and Q4 and there is no limit to how often a hospital may prospectively amend milestones.

G. Payment

HTP participants will be paid monthly throughout the term of the program. Payments of at-risk dollars made for Q4 of the ramp up period (Application Period) will be determined by the participant's successful completion of their Program Application. Payments of at-risk dollars made for PY1 will be determined by the participant's successful completion of their Implementation Plan and in part, on successfully reporting in each participant's quarterly filings. Payments of at-risk dollars for PY2 to PY5 (Oct. 2022 – Sept. 2026) will, in part, be based on ongoing reporting of milestones and interim activities in each participant's quarterly filings.

V. Program Timeline



Appendix A - Colorado Hospital Index Measure – Hospital Transformation Program

Milestone Reporting

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I. Hospital Index Measure: Background

The SW-COE1 Hospital Index Measure is a statewide measure of avoidable care across procedural episodes. A hospital's index score will be compared to a baseline index score.
The Hospital Index Measure is designed to stand up and support a continuous learning environment, which may then be leveraged for other interventions or hospital processes. Hospitals can best address this measure by following the laid out guidance, particularly for reporting performance for the impact milestone for PY2Q2 (Jan. – Mar. 2023) and the continuous learning and improvement milestones starting PY2Q4 (Jul. – Sept. 2023) until the end of the program. There are pre-defined milestones to support achievement of the Hospital Index Measure.

A. PY2Q2 (Jan. – Mar. 2023) Impact Milestone: Current Quality Improvement Capacity in Key Functional Areas

The impact milestone should evaluate the current quality improvement capacity in key functional areas. If one or more functional areas are not applicable to the intervention, the hospital should demonstrate that. The achievement of the impact milestone will be dependent on the milestone's activities being successfully completed. The achievement of the final impact milestone will indicate the conclusion of the Planning and Implementation phase for that intervention and all future milestones should be designated as Continuous Improvement phase milestones. Hospitals will be required to have an impact milestone no later than PY2Q2 (Jan. – Mar. 2023) and continuous improvement milestones beginning no later than PY2Q4 (Jul. – Sept. 2023).

The Department will use the following questions and prompts when evaluating Hospital Index milestones. This includes questions to investigate a hospital's current capacity to run effective quality improvement (QI) initiatives through the lens of applicable functional areas and help uncover gaps that could deter from success in the HTP's continuous improvement phase.

Functional Areas to address:

- People: workforce development; identification key project personnel
- Process: shifts in clinical and quality processes;
- Technology: updating, acquisition or repurposing underlying electronic health data storage; data use; data exchange
- Patient Engagement / Target population: identification of patients that fall within target populations;

Impact Milestone Functional Area – People:

1. *Governance Structure – (Predefined element to demonstrate impact milestone; required)*

a. Describe the quality improvement governance structure at your hospital and include an organizational chart where appropriate. Include roles including departmental or unit-based leadership positions, data analysts and executive leadership positions related to quality improvement.

2. *Staff Engagement – (Predefined element to demonstrate impact milestone; required)*

   a. How does your hospital engage interdisciplinary teams in quality improvement efforts?
   b. Does your hospital offer protected time to quality leadership or frontline staff to engage in quality improvement initiatives?
   c. How does the hospital engage quality leaders in institutional quality initiatives?
   d. How do quality leaders engage frontline staff in quality improvement initiatives?
   e. How does your hospital disseminate performance data related to quality initiatives to staff in both quality leadership positions and frontline positions? (i.e. accessible dashboards, report distribution, presentations at regularly scheduled series or huddles, public postings in patient accessible areas, etc.).

3. *Professional Development – (Predefined element to demonstrate impact milestone; required)*

   a. How does your hospital teach quality improvement skills and rapid cycle improvement techniques (i.e. Six Sigma Lean, Plan-Do-Study-Act (PDSA) Framework, Model for Improvement, etc.)[2] to staff across all levels?

Impact Milestone Functional Area – Process:

1. *Readiness – (Predefined element to demonstrate impact milestone; required)*

   a. Hospital Index measure requires the HTP team to coordinate with teams from different departments to maintain or improve performance in the top five highest weighted episode groups. How will your hospital leverage your current quality structure to monitor hospital index performance and implement quality improvement initiatives to meet your performance target?
   b. What gaps exist in your current quality structure that you will need to address to successfully run a continuous quality improvement effort for this measure?

Impact Milestone Functional Area – Technology:

1. *Analytics – (Predefined element to demonstrate impact milestone; required)*

[2] For more information and helpful resources, please see Appendix B of this document.

a. Describe the staff available to analyze and report hospital level quality data and from what sources this team can obtain relevant data (i.e. electronic health record (EHR), claims engine, etc.).
b. Is the analytics team centralized? Does this team primarily focus on hospital level measures? Are additional analysts available to assist local quality initiatives?
c. The following procedure codes in the chart below are used to calculate performance in the Hospital Index measure. After consulting with your analytics team, what is the feasibility of monitoring the frequency of these procedures in a recurring report by service area?

Episode Description	Episode Type
Bariatric Surgery	Procedural
Breast Biopsy	Procedural
C-Section	Procedural
CABG &/or Valve Procedures	Procedural
Cataract Surgery	Procedural
Colonoscopy	Procedural
Colorectal Resection	Procedural
Coronary Angioplasty	Procedural
Gall Bladder Surgery	Procedural
Hip Replacement / Revision	Procedural
Hysterectomy	Procedural
Knee Arthroscopy	Procedural
Knee Replacement / Revision	Procedural
Lumbar Laminectomy	Procedural
Lumbar Spine Fusion	Procedural
Lung Resection	Procedural
Mastectomy	Procedural
Pacemaker / Defibrillator	Procedural
Prostatectomy	Procedural
Shoulder Replacement	Procedural
Tonsillectomy	Procedural
Transurethral Resection Prostate	Procedural
Upper GI Endoscopy	Procedural
Vaginal Delivery	Procedural

Impact Milestone Functional Area - Patient Engagement / Target Population:
(Predefined elements to demonstrate impact milestone; required)

1. While not directly measured in the course of your effort to improve your hospital index performance, begin to consider how your effort to monitor potentially avoidable costs (PAC) could impact patient experience, delivery of care, outcomes and/or satisfaction.

2. Describe how the hospital will utilize its Hospital Index dashboard and information to monitor PAC performance and equity for patients by reviewing disaggregated data by race, ethnicity, language, gender, etc., and how that could impact how the hospital approaches patient experience, delivery of care, outcomes, or satisfaction.

B. Continuous Learning and Improvement Milestones

After the State reports performance on the Hospital Index measure, these questions guide a hospital through key assessments and planning steps to begin their continuous improvement process. Hospitals should also describe their plan to implement quality improvement strategies to improve or maintain their Index performance. Please see Appendix B for additional resources on conducing current state assessments and planning out the continuous improvement process.

PY2Q4 (Jul. – Sept. 2023) Milestone:

1. *Current State Assessment of Top 5 Episodes Driving the Hospital Index Score (Predefined element for Q4 milestone each PY beginning with PY2 (Oct. 2022 – Sept. 2023); required)*

   a. In the chart below, list the top 5 episodes with the greatest weighted impact on your Hospital Index score and indicate what type of action is needed to achieve the state set benchmark (i.e. Maintain performance or improve)?

Top 5 Episodes	Maintain or Improve Performance?
1.	
2.	
3.	
4.	
5.	

   b. For each episode, please answer the following questions (Required):

      i. Number of clients associated with specified episode:
      ii. Top 2 categories of service for each episode:

   c. Consider factors such as the procedure code or DRG, provider type, service location, and specific rendering/attending providers that drive high/low PAC in this episode to answer the following questions:

      i. What is driving PAC?
      ii. What is contributing to low PAC?
      iii. Are there any themes/trends in services used more/less within an episode type that are associated with high/low PAC?
      iv. Provide demographic stratifications associated with this episode including: age, race, gender, and county.

2. *Stakeholder Assessment – (Predefined element of first continuous learning and improvement milestone, required)*

    a. Proposed approach for each episode, please answer the following questions to identify and assess stakeholders that you must engage to implement a quality improvement initiative.

        i. Describe the stakeholders that must be engaged to implement a quality improvement initiative to improve this episode's PAC.
        ii. Based on your current perception, are the stakeholders impacted by the project in agreement that improvement is needed?
        iii. Based on your current perception, please rate the collective commitment to this project regarding the stakeholders involved.
        iv. Based on your current perception, please assess the local environment's readiness for change.

3. *Continuous Improvement Activities, Impact and Reporting – (Predefined element of first continuous learning and improvement milestone, required)*

    a. Please describe the approach to the quality initiative(s) required to improve your index score. Describe what continuous learning and improvement model(s)/strategies you will be implementing (rapid cycle improvement, etc.). Below are suggested ways to approach this:

        i. Describe your next intervention indicating how long each test cycle will last and how many tests you hope to complete during the next reporting cycle.
        ii. Comment on the scope of your intervention with the following considerations:
            - Where will the intervention take place?
            - What population will it focus on?
            - What is the size of the population it will affect?
            - Can you ensure the first test of your intervention has a minimized scope?
        iii. What will you measure to know that you have successfully implemented the intervention for your initial rapid cycle test of change?
        iv. What will you measure to know if your intervention led to an improvement? (i.e. describe a proxy measure to assess progress towards the state set benchmark).
        v. Describe the data collection and reporting method for each intervention's process and proxy outcome measures.
        vi. Describe your process for reviewing and disseminating the results of your first test of change. How you will engage the necessary stakeholders and then plan to either abandon, alter or implement at a larger scale?

PY3Q2 (Jan. – Mar. 2024) Milestone:

1. *Continuous Improvement Activity, Impact and Reporting (Predefined element of each milestone each PY beginning with PY3 (Oct. 2023 – Sept. 2024); required)*

Provide a narrative explanation responding to the following questions indicating whether your hospital has maintained your original improvement strategy or adopted a new one.

a. Describe your next intervention cycle and what you plan to complete during the next reporting cycle.
b. Please describe your current continuous quality improvement strategy to improve or maintain the top 5 episodes impacting your Hospital Index Score.
c. Please describe how you plan to either continue with the current strategy or adapt it to achieve the desired outcome in your Hospital Index Score.
d. What and how do you plan to report out to key stakeholders regarding what was learned during the next cycle?

Appendix B - Quality Improvement Resources – Hospital Transformation Program

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I. Quality Improvement Resources

As part of the continuous learning and improvement milestones, hospitals implement and describe their strategies to evaluate or improve their performance. A quality improvement program includes activities, such as monitoring, analyzing, and improving the quality of processes, aimed at specific health outcomes in a healthcare organization. The following sections detail additional resources on conducting current state assessments and planning out the continuous improvement process:

- Models for Improvement
- Assessment Tools
- Stakeholder Engagement Toolkits
- Care Coordination and Service Delivery Best Practices

While these resources are not meant to be exhaustive, hospitals may consider this list to assist in overall quality improvement initiatives.

A. Models for Improvement

1. **Resource**: Practice Facilitation Handbook, *AHRQ.* Accessed online: https://www.ahrq.gov/ncepcr/tools/pf-handbook/index.html

   Key Takeaways: The Practice Facilitation Handbook is designed to assist in the training of new practice facilitators as they begin to develop the knowledge and skills needed to support meaningful improvement in primary care practices. The handbook consists of 21 training modules, each 30 to 90 minutes long with varying requirements for pre-session preparation for learners. Each module contains a Trainer's Guide, which includes a checklist of materials, the learning objectives for the session, and a list of readings and activities designed to develop basic knowledge and skills.

2. **Resource:** Science of Improvement: How to Improve, *Institute for Healthcare Improvement (IHI).* Accessed online: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

   Key Takeaways: The Model for Improvement, developed by Associates in Process Improvement, is a simple yet powerful tool for accelerating improvement. This model has been used very successfully by hundreds of health care organizations in many countries to improve many different health care processes and outcomes. The source includes information to support such quality improvement activities as developing the AIM statement, establishing measures, completing a PDSA worksheet, spreading change, and more.

3. **Resource:** Model for Improvement, *Qualis Health.* Accessed online: http://medicare.qualishealth.org/qi-basics/model-for-improvement

   Key Takeaways: The Model for Improvement is a time-tested method of quality improvement that is simple, highly effective, and supports a bottom-up approach to change. This resources includes a fillable worksheet and a webinar.

4. **Resource:** Worksheet for Plan-Do-Study-Act (PDSA) Cycle Planning, *AHRQ*. Accessed online: https://www.ahrq.gov/evidencenow/tools/pdsa-worksheet.html

   Key Takeaways: This worksheet is for primary care staff to help plan a quality improvement (QI) Plan-Do-Study-Act (PDSA) cycle, outlining the QI goals and how the practice will try to reach them, as well as providing space for actual outcomes and analysis of next steps.

5. **Resource:** QI Tips: A Formula for Developing a Great Aim Statement, *National Institute for Children's Health Quality.* Accessed online: https://www.nichq.org/insight/qi-tips-formula-developing-great-aim-statement

   Key Takeaways: This webpage includes guidance on how to write a great aim statement. The aim statement is a clear, explicit summary of what your team hopes to achieve over a specific amount of time including the magnitude of change you will achieve. The aim statement guides your work by establishing what success looks like.

6. **Resource:** Worksheet for Developing Your Quality Improvement Project, *John Hopkins Medicine*. Accessed online: https://www.hopkinsmedicine.org/armstrong_institute/_files/patient%20safety%20and%20quality%20improvement%20project%20tools/spirit_toolkit/module%203_worksheet%20for%20qi%20project.pdf

   Key Takeaways: A worksheet that includes guidance in writing an aim statement, establishing measures, selecting changes, testing changes, and writing a project summary.

B. Assessment Tools

1. **Resource**: Organizational Quality Assessment Tool, *HEALTHQUAL.* Accessed online: https://healthqual.ucsf.edu/sites/g/files/tkssra931/f/HEALTHQUAL%20OA_February%202018.pdf

   Key Takeaways: Organizational structure is fundamental to quality improvement success, and involves a receptive health care organization, sustained leadership, staff training and support, time for teams to meet, and data systems for tracking outcomes. This Organizational Assessment is a tool to evaluate the structure.

2. **Resource:** Registries for Evaluating Patient Outcomes: A User's Guide: 4th Edition, AHRQ. Accessed online: https://effectivehealthcare.ahrq.gov/products/registries-guide-4th-edition/users-guide

   Key Takeaways: The fourth edition of the AHRQ publication, "Registries for Evaluating Patient Outcomes: A User's Guide," is a reference handbook that provides best practices to guide design, operation, analysis, and evaluation of patient registries. It provides concise, practical information to help registries address technological and other changes.

3. **Resource:** Population Health Resource Library, *Advisory Board.* Accessed online: https://www.advisory.com/topics/population-health-roi/2020/04/pha-resource-library

   Key Takeaways: This resource library is a collection of care decision guides, scripting, governance documents, tools, risk assessments, and evaluation forms that are critical to the success of operating population health initiatives. This library includes ready-to-use resources you can download and tailor to optimize your initiatives.

4. **Resource:** The EveryONE Project Toolkit, *American Academy of Family Physicians.* Accessed online: https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit.html

   Key Takeaways: AAFP's EveryONE Project promotes diversity and addresses SDOH to advance health equity in all communities. The initiative offers education and resources to help you advocate for health equity, promote workforce diversity, and collaborate with other disciplines and organizations to reduce harmful disparities. This toolkit offers strategies for use in one's practice and community to improve patient health and help individuals thrive.

5. **Resource:** Screening for Social Determinants of Health in Populations with Complex Needs: Implementation Considerations, *Center for Health Care Strategies.* Accessed online: https://www.chcs.org/media/SDOH-Complex-Care-Screening-Brief-102617.pdf

   Key Takeaways: This brief examines how organizations participating in Transforming Complex Care, a multi-site national initiative funded by the Robert Wood Johnson Foundation, are assessing and addressing SDOH for populations with complex needs. It reviews key considerations for organizations seeking to use SDOH data to improve patient care, including: (1) selecting and implementing SDOH assessment tools; (2) collecting patient-level information related to SDOH; (3) creating workflows to track and address patient needs; and (4) identifying community resources and tracking referrals.

6. **Resource:** Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE), *National Association of Community Health Centers.* Accessed online: https://www.nachc.org/research-and-data/prapare/

Key Takeaways: The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is a national effort to help health centers and other providers collect the data needed to better understand and act on their patients' social determinants of health. The PRAPARE assessment tool consists of a set of national core measures as well as a set of optional measures for community priorities. As providers are increasingly held accountable for reaching population health goals while reducing costs, it is important that they have tools and strategies to identify the upstream socioeconomic drivers of poor outcomes and higher costs.

7. **Resource:** Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants, *CDC.* Accessed online: https://stacks.cdc.gov/view/cdc/20707

   Key Takeaways: Effective planning and decision-making for improving the health of a community requires good information about current health status and factors that will influence that health status. This document identifies the metrics - the population health outcomes and important risk and protective factors - that, when taken together, can describe the health of a community and drive action. Selection of these metrics reflects the weight of professional and academic judgment over the past three decades.

8. **Resource:** Blueprint for Complex Care, *The National Center for Complex Health & Social Needs.* Accessed online: https://www.nationalcomplex.care/wp-content/uploads/2019/03/Blueprint-for-Complex-Care_UPDATED_030119.pdf

   Key Takeaways: The Blueprint for Complex Care is a guide for advancing the field of complex care. NCCHSN gathered diverse, far-reaching perspectives through reviews of published literature, interviews, surveys, and an expert convening to develop a comprehensive understanding of the current state of complex care, and to shape our recommendations for strengthening the field. It outlines the current state of complex care and includes recommendations for the future.

C. Stakeholder Engagement Toolkits

1. **Resource:** One Health Stakeholder Mapping Toolkit, *USAID*. Accessed online: https://s3.amazonaws.com/one-health-app/static/docs/toolkits/Stakeholder_Mapping_Toolkit/Stakeholder_Mapping_Toolkit_Overview.pdf

   Key Takeaways: This toolkit will guide you through the process of planning and executing stakeholder mapping. In addition to a step-by-step process, this toolkit also contains helpful tips and important considerations in the text boxes placed throughout the document.

2. **Resource:** Stakeholder Mapping, *Reproductive Health National Training Center*. Accessed online: https://rhntc.org/sites/default/files/resources/fpntc_stakeholder_mapping_2020-04-27.pdf

   Key Takeaways: Stakeholder mapping is a tool used to analyze and prioritize the engagement of stakeholders when you are planning to implement an initiative. This tool will help you and your team generate information about stakeholders to understand their interests and assess their influence in order to successfully implement and sustain a new initiative.

3. **Resource:** Stakeholder Mapping, *Center for Creative Leadership*. Accessed online: https://www.countyhealthrankings.org/sites/default/files/media/document/resources/Stakeholder%20Mapping.pdf

   Key Takeaways: This stakeholder analysis will help identify an individual's or group's interest, position, or other special factors that should be considered during the decision-making process.

D. Care Coordination and Service Delivery Best Practices

1. **Resource:** Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs, *IHI*. Accessed online: http://www.ihi.org/resources/Pages/IHIWhitePapers/IHICareCoordinationModelWhitePaper.aspx

   Key Takeaways: This IHI white paper outlines methods and opportunities to better coordinate care for people with multiple health and social needs, and reviews ways that organizations have allocated resources to better meet the range of needs in this population. There is special emphasis on the experience of care coordination with populations of people experiencing homelessness.