COLORADO
Colorado Healthcare Affordability & Sustainability Enterprise

HOSPITAL TRANSFORMATION PROGRAM COMMUNITY AND HEALTH NEIGHBORHOOD ENGAGEMENT GUIDEBOOK

Table of Contents

I. Community and Health Neighborhood Engagement Process Overview 2

II. Community and Health Neighborhood Engagement Guidance 3

A. Stakeholder Engagement 3

B. Environmental Scan 6

C. HTP Project Planning 11

III. Timeline and Deliverables 13

A. CHNE Process Timeline 13

B. CHNE Deliverables 15

C. Overview of Submission and Review Process for Deliverables 18

D. Technical Assistance 18

Appendix I: RAE Requirements Related to the HTP and CHNE 19

A. Background Information 19

B. Specific RAE Contractual Requirements Related to the Hospital Transformation Program and Community Engagement 19

C. Other Relevant Contractual Requirements 21

Appendix II: Community Inventory Tool 25

Clinical and Behavioral Health Providers 25

Appendix III: Hospital Care Transitions Activities Inventory Tool 27

Appendix IV: HTP Framework 29

I. Community and Health Neighborhood Engagement Process Overview

Hospitals seeking to participate in the Hospital Transformation Program (HTP) are required to engage with community organizations and health neighborhoods as they plan for their HTP participation. Specifically, hospitals must conduct an environmental scan that is informed by external feedback and seek meaningful input on their project development and program applications during the pre-waiver period. The goal of the required community engagement process – including the environmental scan - is to inform the selection of HTP projects that are based on a solid understanding of the health needs of the population and the resources available to address them that will help achieve the Quadruple Aim: better patient experience, improved health outcomes, improved provider experience, and reduced cost. Furthermore, this engagement at the outset of the HTP will be critical to ensuring successful collaborations and delivery system impacts throughout and following the HTP.

This document provides guidance to hospitals as they plan their pre-waiver Community and Health Neighborhood Engagement (CHNE) process. It includes requirements and provides links to additional resources that will help HTP participants successfully engage community organizations during the pre-waiver planning process when identifying community needs and determining their approach to the HTP application.

II. Community and Health Neighborhood Engagement Guidance

A. Stakeholder Engagement

The CHNE process is intended to build on the strong spirit of collaboration within Colorado's health system and efforts and partnerships already underway. Program participants will be expected to engage, consult, and be informed by health neighborhoods and community organizations to identify community needs and inform the selection of transformation initiatives that address those needs during the planning process.

The CHNE process should be intentional and formal and should be designed to inform decision-making and leadership. Program participants may determine how best to undertake a CHNE process that will provide meaningful input; however, program participants must demonstrate that the process is inclusive and meaningful.

Inclusivity

Hospitals will be required to demonstrate that they have solicited and incorporated into their planning and applications input from a broad cross-section of the community and Health Neighborhood[1], including clinical providers and organizations that serve and represent the broad interests of the community and those specific to HTP priority populations and project topics, including but not limited to:

- Regional Accountable Entities (RAEs);
- Local Public Health Agencies (LPHAs);
- Mental Health Centers;
- Community Health Centers, including Federally Qualified Health Centers and rural health centers;
- Primary Care Medical Providers (PCMPs);
- Regional Emergency Medical and Trauma Services Advisory Councils (RETACs);
- Long Term Service and Support (LTSS) Providers;
- Community organizations addressing social determinants of health;
- Health Alliances; and
- Consumer advocates/advocacy organizations

While RAEs are contractually obligated to engage with hospitals in the HTP (see Appendix 1 for RAE requirements related to this effort), hospitals should make concerted efforts to actively recruit community partners as necessary and should have a plan for addressing gaps in needed input.

Outreach

The Department of Health Care Policy and Financing (the Department) has conducted initial outreach to key stakeholders, such as RAEs and Health Associations. In following up to engage stakeholders, hospitals should be clear about the purpose of the engagement effort, who should

[1] Health Neighborhood providers include: specialty care, LTSS providers, Managed Service Organizations and their networks of substance use disorder providers, hospitals, pharmacists, dental, non-emergency medical transportation, regional health alliances, public health, Area Agencies on Aging, Aging and Disability Resources for Colorado, and other ancillary providers such as Colorado Crisis Services vendors.

be engaged, and why engagement is worthwhile. Hospitals should seek to engage respected organizations with community and subject matter expertise. Hospitals and community organizations should frame their planning efforts around a common goal, such as improving the lives of community members, improving care processes, capitalizing on resources and incentives, coordinating efforts and/or avoiding unnecessary duplication of efforts.

Hospitals should be prepared for a variety of responses from the community and may need to plan for proactive recruitment as needed. As outlined in the section on Technical Assistance below, support will also be available from the Department if hospitals encounter barriers in conducting their outreach.

Convening Partners to Support Meaningful Engagement

Leveraging existing forums and collaborations will help to maximize community participation. Hospitals should align their engagement activities with advisory groups, existing programs and alliances, and statewide initiatives designed to strengthen the health care system.

Hospitals should be sensitive to the possibility that many hospitals may be requesting time at the same forums and / or with the same stakeholders, and should coordinate (e.g., around region or topic) to reduce undue burden on community partners. This should include collaborating with the conveners of existing forums on the most appropriate way to leverage those forums. This will further increase the likelihood of stakeholder engagement.

Groups should be convened at regular intervals to reduce confusion. A diverse range of venues, locations, times and manners should be used to provide flexibility and to meet the goal of the engagement activity, for example:

Engagement Type	**Engagement Goal**	**Engagement Activity/Forum**
Consultation	Provide community perspective	• Focus groups • Interviews • Surveys
Involvement	Provide perspective and information that drives decision-making	• Advisory Committees • Public forums • Discussion groups
Partnership	Actively participate in decision-making	• Topic-Specific workgroups • Meetings

Notice of engagement activities and forums, as well as the purpose of the engagement should be made in advance and in a manner appropriate for the activity. For example, if the goal is to attract a large, diverse group, such as for a public forum, notice may involve broad outreach and advertising unlike for a topic-specific workgroup where members would be identified in advance and help determine meeting schedules. All venues used should provide opportunities for bi-directional communication: in addition to receiving community input, hospitals should use venues to share outcomes and updates. This will not only maximize transparency but develop a common understanding among all partners that facilitates productive discussions. See the list of Additional Resources below for more best practices and examples of outreach and engagement.

Additional Resources

Creighton, James. 2005. The Public Participation Handbook: Making Better Decisions Through Citizen Involvement. Jossey-Bass.

Chapter 6 Techniques for Getting Information to the Public, pp. 89-102

Chapter 7 Techniques for Getting Information from the Public, pp. 103-135

NIH Report: Principles of Community Engagement, Second Edition
https://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

Community Places: Community Planning Toolkit - Community Engagement
https://www.communityplanningtoolkit.org/sites/default/files/Engagement0815.pdf

Metropolitan Area Planning Council (MAPC). 2016. Community Engagement Guide. Boston.
http://www.concordma.gov/DocumentCenter/Home/View/5727

B. Environmental Scan

The environmental scan should be an evidence-based, comprehensive assessment of the demographics and health needs of the community to be served and the resources currently available in the service area to address health needs and the social determinants of health. This comprehensive assessment will help to identify needed services, resources and connectivity that may be corrected through HTP projects. Presented below are the requirements for the environmental scan, as well as additional resources to assist hospitals in conducting the scan and finding data sources.

The environmental scan should include both qualitative information gathered in various forums, such as themes from key informant interviews and focus groups, as well as quantitative data about the service population's demographics and health needs. In addition to the hospital's clinical and utilization data, hospitals should incorporate data that partners (RAEs and others) can provide to understand their community. Hospitals may include information from recently-completed Community Health Needs Assessments provided they seek input on findings from community organization partners.

Evidence-Based and Data-Driven

Hospitals will be required to identify and use data and other sources of information in determining community health needs and existing resources and, subsequently, conducting an informed decision-making process to select initiatives within the HTP priority populations and project topics. To the extent possible, hospitals should leverage available information sources and data, including data provided by the department, data provided by community partners, and recently-completed Community Health Needs Assessments. Hospitals should ensure that the sources used include data and information specific to HTP priority populations and project topics.

Description of the Community to Be Served

The environmental scan should assess the demographics and health status and needs of the community to be served. This should include basic information about the Medicaid and uninsured population as well as information about the populations of focus within the HTP:

- Individuals with significant health issues, co-occurring conditions, and / or high health care utilizers;
- Vulnerable populations including related to maternal health, perinatal, and improved birth outcomes as well as end of life care;
- Individuals with behavioral health and substance use disorders;
- Other populations of need, including those at-risk of being high utilizers to whom interventions could be targeted and populations that may not currently receive care in the hospital but are known to community organizations.

Population demographics should include those who are institutionalized and/or involved in the criminal justice system. Demographics should include (when available):

- Race;
- Ethnicity;
- Age;

- Income and employment status;
- Disability status;
- Immigration status;
- Housing status;
- Education and health literary levels;
- Primary languages spoken; and
- Other unique characteristics of the community that contribute to health status, which may include, but are not limited to:
  - ✓ Gender/Gender orientation
  - ✓ Sexual orientation
  - ✓ Mobility
  - ✓ Medicaid/insurance status
  - ✓ Access to a regular source of care
  - ✓ Urban/rural status

The environmental scan must include an assessment of the health status of the population and the distribution of health issues. Attention should be paid to identification of issues related to health disparities and high-risk populations within the Medicaid and uninsured population. This population assessment should include the prevalence of significant behavioral and physical health needs generally in the service area, specifically:

- Mental health and substance use disorder burdens for both the Medicaid population and the general population (Serious Mental Illnesses and Substance Use Disorders, including alcohol, tobacco and opiate abuse);
- Chronic physical disease burdens for both the Medicaid population and the general population (including rates for the top physical chronic conditions)
- Other significant behavioral and physical health needs in your service area that align with the populations and project topics of focus within the HTP:
  - ✓ Top chronic conditions accounting for most utilization (include both physical and behavioral health chronic diseases);
  - ✓ Physical health conditions that commonly co-occur with mental health diagnoses;
  - ✓ Related to maternal health, perinatal, and improved birth outcomes; and
  - ✓ Related to end of life care.

In completing this assessment, hospitals should consider:

- The leading causes of death and premature death by demographic and geographic groupings, and analysis of trends over time;
- The leading causes of hospitalization and preventable hospitalizations by demographic and geographic groupings and analysis of trends over time;
- The rates of ambulatory care sensitive conditions, including chronic disease diagnoses such as hypertension, diabetes, obesity and asthma, and rates of risk factors that exacerbate health status;
- Disease prevalence such as diabetes, asthma, cardiovascular disease, hypertension, depression, HIV and STDs, etc.;
- Maternal and child health outcomes including infant mortality, low birth weight, high risk pregnancies, birth defects, as well as access and quality of prenatal care;

- Health risk factors such as obesity, smoking, drinking, drug overdose, physical inactivity; and
- Needs related to major social determinants of health.

Access to and Availability of Services

The environmental scan should include a succinct narrative description of the health and social determinants of health resources available in the community that includes assessment of the adequate capacity and quality of those services. Services to be assessed should include but are not limited to:

- Primary care;
- Specialty care;
- Long term care;
- Complex care management;
- Care coordination via primary care or other providers;
- Maternal health, perinatal, and improved birth outcomes;
- End of life care;
- Behavioral health;
- Other outpatient services;
- Population screenings, outreach, and other population health supports and services;
- Care transition supports among specific populations or across major service delivery systems; and
- Social Supports, including:
  - ✓ Housing and homelessness assistance
  - ✓ Legal, medical-legal and financial assistance
  - ✓ Nutrition programs
  - ✓ Employment and job training
  - ✓ Transportation

- Other areas of significant capacity gaps, which may include:
  - ✓ Federally Qualified Health Centers
  - ✓ Ambulatory surgical centers
  - ✓ Urgent care centers
  - ✓ Local health departments
  - ✓ Dental providers
  - ✓ Rehabilitation services
  - ✓ The full range of inpatient services
  - ✓ Home care services
  - ✓ Managed care organizations
  - ✓ Disease management services

See Appendix 2 for a checklist that may provide a useful starting point for this assessment as it relates to care transitions from the hospital setting. This assessment should consider how access to healthcare and other resources varies for the Medicaid population, as well as the availability of providers, what portion of the population has regular health care providers, and what portion of the population has costs or other barriers for getting health care and other needs met.

In addition to the narrative assessment of access to and availability of services, hospitals must inventory their facilities in the community. The below chart provides a starting point for this inventory.

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

Health Information Exchange

The environmental scan should include an assessment of the current state of health information exchange. Hospitals should assess both data flow within the community and between partners, including data use agreement and data sharing; and the hospital's current capabilities regarding data exchanges across network providers, external partners and with the Colorado Regional Health Information Organization or regional data exchanges. Hospitals must address, specifically, how this impacts care transitions and complex care management.

Workforce

The environmental scan should include an assessment of the state of adequate healthcare workforce recruitment and retention. Hospitals should assess gaps in workforce needed to meet the community needs identified in the above sections and what impact closing these gaps would have on the workforce.

Resources

Community Health Improvement including the Assessment Process

Healthy People 2020: MAP-IT: A Guide to Using Healthy People 2020 in your Community
http://www.healthypeople.gov/2020/Implement/default.aspx

http://www.healthypeople.gov/2020/implement/MapIt.aspx

Mobilizing for Action through Planning and Partnerships (MAPP)
http://www.naccho.org/topics/infrastructure/mapp/

NACCHO Community Health Assessment and Improvement Planning
http://www.naccho.org/topics/infrastructure/CHAIP/index.cfm

County Health Rankings: Tools and Resources related to Assessing Needs and Resources
http://www.countyhealthrankings.org/resources?f[0]=field_resource_type%3A108&f[1]=field_global_action%20_steps%3A18389

Data Sources[2]

Colorado Department of Public Health and Environment: Data page

https://www.colorado.gov/pacific/cdphe/data

Colorado Department of Health Care Policy and Financing: Research, Data and Grants page
https://www.colorado.gov/pacific/hcpf/research-data-and-grants

Colorado Health Institute: Data page https://www.coloradohealthinstitute.org/data

County Health Rankings www.countyhealthrankings.org/

2 Please note that qualitative data, including key informant interviews, should be used to give quantitative data context.

C. HTP Project Planning

Identifying Target Populations and Project Partners

The results of the environmental scan, input from engaged organizations, and the HTP priorities should form the basis of the hospital's decisions regarding which community needs to prioritize, which populations to target and potential partnerships. Hospitals are encouraged to partner with community organizations, such as the RAEs, as both resources and collaborators.

Initiative Selection

Initiatives proposed in HTP Applications must likewise address the needs identified in the environmental scan and HTP program priorities, as well as reflect the community's input. Initiatives should appropriately, effectively, and efficiently build upon and – as appropriate – utilize community resources identified in the environmental scan and should not duplicate existing resources.

The decision-making process to select initiatives and target populations should be informed by:

- The priorities of the HTP
- Other state initiatives underway
- Current hospital initiatives; and
- The continuing needs and available resources of the community.

Initiatives should address the following HTP populations and focus areas, described in more detail in the HTP Framework in Appendix 4.

- High Utilizers
- Vulnerable Populations (including pregnant women and the elderly)
- Behavioral Health and SUD Coordination
- Clinical and Operational Efficiencies
- Community Development Efforts to Address Population Health and Total Cost of Care

Initiatives will be reviewed as part of the hospital's application to the HTP for the following:

- Connection to the HTP priorities;
- The evidence-based rationale for the initiative's selection, including its nexus to the HTP goals and the community needs identified through the CHNE process; and
- How the initiative intersects with the hospital's existing efforts, assets, resources, and reimbursements.

Existing hospital initiatives that demonstrate the above may be appropriate if there is no duplication of funding, but hospitals must consider how to optimize these for the HTP if they are being considered for inclusion in their HTP application. Hospitals should note that expectations for performance and milestone achievement for existing initiatives may differ from expectations for new initiatives. See Appendix 3 for an inventory of activities that may help to identify gaps in existing initiatives related to care transitions from the hospital.

Program Evaluation Approach

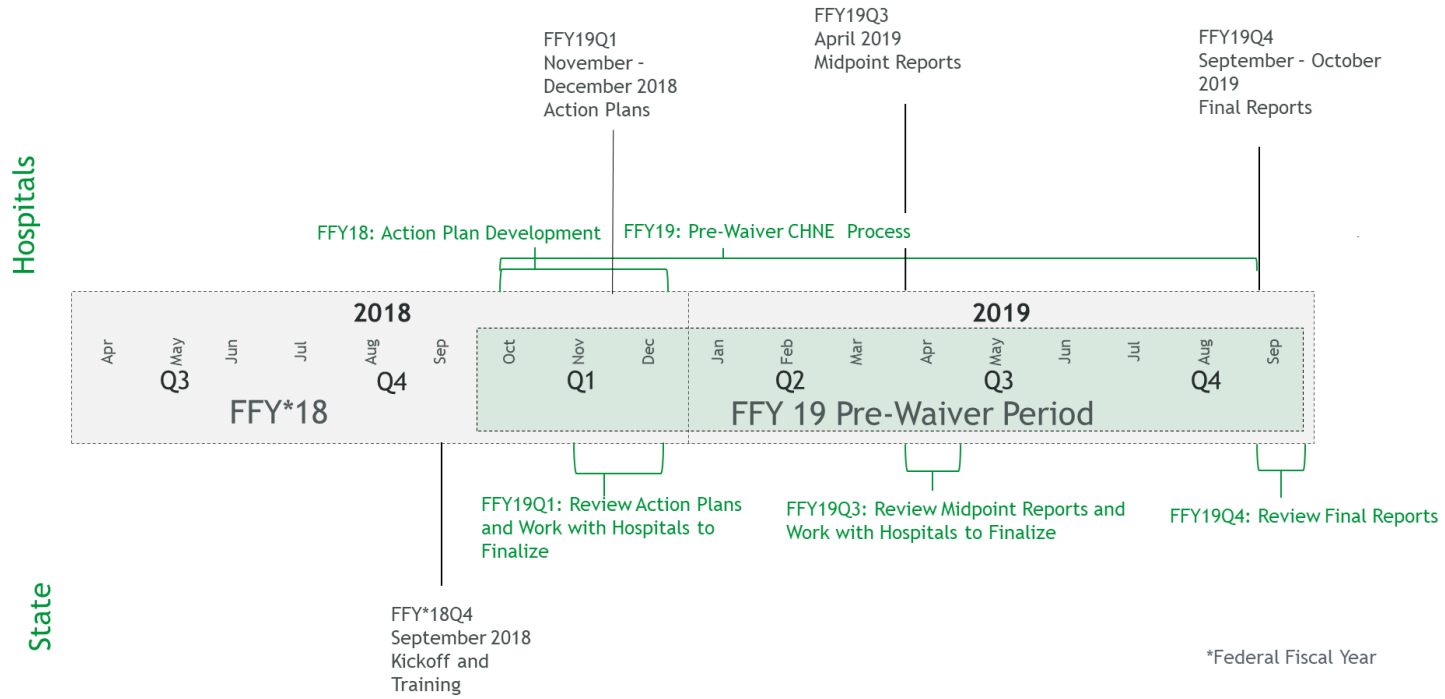
The HTP will be evaluated based on milestones and process measures, as well as identified outcome measures. Hospitals will be expected to report data on a regular basis. Milestones,

process measures, and outcome measures will also form the basis for the program's pay-for-performance component.

III. Timeline and Deliverables

A. CHNE Process Timeline

Below is a timeline outlining the major phases and deliverables of the CHNE process. Hospitals are expected to use the first half of the process, November 2018 to March 2019, to engage community organizations, collect data, and complete an environmental scan. This effort will prepare hospitals to use the remainder of the time, April to September 2019 to prioritize community needs and plan their HTP application.



Hospitals

Federal Fiscal Year 2018 (FFY18): CHNE Action Plan Development

FFY19: Pre-Waiver CHNE Process

FFY19Q1: November to December 2018 Action Plans

FFY19Q3: April 2019 Midpoint Reports

FFY19Q4: September to October 2019 Final Reports

State

FFY18Q4: September 2018 Kickoff and Training

FFY19Q1: Review Action Plans and Work with Hospitals to Finalize

FFY19Q3: Review Midpoint Reports and Work with Hospitals to Finalize

FFY19Q4: Review Final Reports

B. CHNE Deliverables

Action Plan

At the outset of the CHNE Process, program applicants will be required to develop an Action Plan outlining how they will conduct CHNE. The plan should describe:

- What community organizations the hospital intends to engage, how they will reach out to those organizations, and a plan for addressing any gaps in needed input;
- What existing coalitions and meetings they expect to leverage and their collaborative plan for doing so;
- Their strategies for maximizing participation;
- The activities they have planned and the frequency;
- Their plans for noticing activities and sharing updates;
- The sources and information that will be used to identify community health needs and service levels available; and
- Expected challenges and potential solutions, including data and participation gaps.

Hospitals must include letters from their local RAE and at least two other community organizations, as well as letters from the coordinators of coalitions and meetings they intend to leverage, expressing that they are aware of the Action Plan and they intend to participate in the CHNE process. In some cases, these may be the same organizations. Hospitals will be expected to reach out to the Department to seek assistance if they experience difficulties in obtaining these letters.

The State will review Action Plans to ensure:

- The process will be adequately inclusive of organizations that serve and represent the broad interests of the community and that no key stakeholders are excluded;
- The hospital has obtained letters from its local RAE at least two other community organizations expressing that they are aware of the Action Plan and that they intend to participate in the CHNE process;
- There is a plan for proactive recruitment as needed and addressing any gaps in participation;
- Existing forum and collaborations already in place will be leveraged as reasonably feasible and the hospital has obtained letters from coalition and meeting coordinators expressing that they are aware of the Action Plan and that they intend to participate in the CHNE process;
- A diverse enough range of venues, locations, times and manners for engagement will be provided to ensure a meaningful opportunity for participation;
- Opportunities for engagement will be held at regular intervals;
- The venues for engagement will provide opportunities for information to be shared out and input to be received;
- There is a plan for providing adequate notice of engagement opportunities and for providing updates; and
- The program participants have identified or have a process planned for identifying existing Community Health Needs Assessments or other data to complete an evidence-based environmental scan, including identifying community needs and existing resources and gaps.

Via the technical assistance and the review process described below, the State will work with applicants to ensure there is mutual satisfaction with the planned CHNE process and will assist the hospital, as needed, to engage local community organizations, including their local RAE, as required, and to leverage existing coalitions and meetings.

The complete Action Plan Instructions and Template can be found on the Colorado Department of Health Care Policy and Financing website HTP page:
https://colorado.gov/pacific/hcpf/colorado-hospital-transformation-program

Midpoint Report

Midway into the CHNE process, program applicants will be required to provide a Midpoint Report. The report will provide the State with an update on hospitals' work over the first half of the pre-waiver CHNE process to engage community partners in the process and to complete an evidence-based environmental scan, as well as their plan for completing the application with community and health neighborhood input. Specifically, the report should include:

- The community organizations that are engaged;
- Activities undertaken;
- Challenges faced in engaging community organizations and any changes made or strategies used to address those challenges;
- Challenges faced in implementing planned activities and any changes made to the activities proposed in the Action Plan to address those challenges;
- Any other changes made in implementing the Action Plan;
- How they have defined the community (based on input received);
- Detailed findings from the environmental scan regarding the hospital's service area (including related to demographics, needs, resources, gaps, and data exchange infrastructure); data sources and any data gaps should be included;
- Other major discussion topics and input received;
- Their preliminary thinking regarding the likely focus of their HTP initiatives at least regarding target populations and target community needs; and
- An outline for future CHNE activities related to: prioritizing needs; selecting target populations; selecting initiatives; and completing an application that reflects the feedback received.

The State will be reviewing Midpoint Reports to ensure:

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

The complete Midpoint Report Instructions and Template can be found on the Colorado Department of Health Care Policy and Financing website HTP page: https://www.colorado.gov/pacific/hcpf/colorado-hospital-transformation-program

Final Report

At the end of the pre-waiver CHNE process, program applicants must submit a Final Report, which will include information about the entirety of the process but with a primary focus on their efforts to prioritize community needs, identify target populations and initiatives, and develop any partnerships. Specifically, Final Reports must include:

- A list of engaged organizations and the nature of collaborations;
- Summaries of all key activities;
- An outline of feedback sought and received throughout the process and how feedback has been reflected in any adjustments to the CHNE process and planning for HTP participation;
- Decisions regarding:
  - ✓ community needs that will be prioritized in the HTP;
  - ✓ selection of target populations;
  - ✓ opportunities for intervention and initiatives under consideration; and
  - ✓ partnerships;

- Rationale for the above decisions based on:
  - ✓ findings from the environmental scan;
  - ✓ feedback received during the CHNE;
  - ✓ the priorities of the HTP, and other state and hospital initiatives; and

- An outline for future CHNE activities over the duration of the HTP.

The focus of the review of the Final Reports will be:

- to ensure that a broad range of community partners were given meaningful opportunities to provide input into the hospital's planning for its HTP participation;
- that input was reflected in the planning; and
- that HTP initiatives under consideration are tied to the results from a meaningful CHNE process.

The complete Final Report Instructions can be found on the Colorado Department of Health Care Policy and Financing website HTP page: https://colorado.gov/pacific/hcpf/colorado-hospital-transformation-program

C. Overview of Submission and Review Process for Deliverables

Submission

Hospitals will be required to submit all deliverables to the HTP email address COHTP@state.co.us by their stated deadline.

Review Process

The above CHNE deliverables will be reviewed by the Department for completeness and adequacy of response. The Department may request revisions or additional information for its review. As outlined in the timeline, a revision period will allow hospitals to ensure any deficiencies are addressed and that there is agreement between the participant and the State as to the planned process going forward, including addressing any deficiencies in the process to-date.

D. Technical Assistance

Technical assistance is available to applicants as they design, implement, and provide information about their CHNE process. The State will be available to work with participants as they are developing their Action Plans as well as on an ongoing basis up to and including application development to ensure hospitals meet CHNE requirements. Gaps in engagement or information, such as data needed to inform the environmental scan or obtaining needed letters to be included with the Action Plan, should be reported to the state as they are identified so that hospitals may avail themselves of technical assistance to formulate a plan to address the issue by emailing COHTP@state.co.us.

Appendix I: RAE Requirements Related to the HTP and CHNE

A. Background Information

Regional Accountable Entities (RAEs) have replaced Regional Care Collaborative Organizations (RCCOs) and Behavioral Health Organizations (BHOs) as the primary entities responsible for connecting Health First Colorado members with primary and behavioral health care as part of the second phase of the Accountable Care Collaborative (ACC) program. All full benefit Medicaid clients are mandatorily enrolled into the ACC Program except individuals that choose the Program of All-inclusive Care for the Elderly (PACE).

The goal of the RAEs is to assist the Department of Health Care Policy and Finance (the Department) in reducing avoidable and unnecessary costs within the Medicaid program without negatively impacting access to high-value services or positive program outcomes.

B. Specific RAE Contractual Requirements Related to the Hospital Transformation Program and Community Engagement

As the Department looks ahead toward the pre-waiver Community and Health Neighborhood (C/HN) Engagement process that hospitals seeking to participate in the Hospital Transformation Program (HTP) will undertake, it asked us to explore RAE obligations related to the HTP. RAEs are a leading stakeholder that hospitals will seek to engage, and it will be important to understand how to best engage them in the HTP CHNE process. This section outlines such requirements.

HTP Collaboration Requirements

RAEs are explicitly required to collaborate with hospitals implementing the HTP. Specific to the HTP and HTP priorities, RAEs are obligated to:

- Work with the Department to understand how the HTP will work in Colorado and the hospitals' role and responsibilities;
- Help hospitals determine priorities and select projects, interventions and performance goals for the HTP; and
- Collaborate with hospitals to improve care transitions, implement person-centered planning at hospital discharge, and address complex Member needs.

Community Engagement Requirements Generally

RAEs are also required to undertake several initiatives to collaborate with the Department, their communities and regional providers on joint initiatives, including:

- Requirement to coordinate collaboration:
  - ✓ RAEs are required to bring partners together in a regional Program Improvement Advisory Committee (PIAC). The goal of the PIACs is to engage stakeholders and provide guidance on how to improve health, access, cost, and satisfaction of members and providers in the program. This is a forum that hospitals might leverage as a venue for gaining input during their CHNE process.
  - ✓ RAEs are also required to create a Health Neighborhood and Community, which must consist of a diverse network of health care providers and community organizations providing services to residents within the Contractor's geographic region. These also

may be relationships that hospitals can leverage for community input and may provide information to assist with the environmental scan.

There are several other requirements for the RAEs to establish relationships and collaborate with partners. Hospitals could seek to leverage these partnerships and collaborations during the CHNE process or to leverage the knowledge of the RAEs about these needs during their environmental scan. As these requirements align with several HTP priorities, there may also be opportunities for hospitals and RAEs and / or their partners to partner on such initiatives. RAEs are required to:

- Educate hospital discharge planners on processes that support LTSS members and non-institutional discharge options.
- Establish relationships and communication channels with the Department's dental benefit managed care vendor to promote member utilization of the dental benefits.
- Collaborate with local public health agencies to:
  - ✓ Design opportunities for integration of local public health activities into the ACC.
  - ✓ Identify any specific target activities to meet the health needs of members in the region, such as enrollment, health promotion, population health initiatives, and dissemination of public health information.
  - ✓ Explore appropriate funding approaches to support collaborative activities

- Establish relationships and collaborate with economic, social, educational, justice, recreational and other relevant organizations to promote the health of local communities and populations.
- Establish relationships and communication channels with community organizations that provide resources such as food, housing, energy assistance, childcare, education and job training in the region.
- Collaborate with school districts and schools to coordinate care and develop programs to optimize the growth and well-being of Medicaid children and youth.
- Work with community organizations to remove roadblocks to member access to programs and initiatives, particularly evidence-based/promising practice programs in the region.
- Share information with community organizations in the region about identified community social service gaps and needs.
- Engage with hospitals and local public health agencies regarding their community health needs assessments to develop and implement collaborative strategies to reduce health inequities and disparities in the community.
- Collaborate with other RAEs to help serve any enrolled members who reside within the geographic region of another RAE.
- Collaborate with other RAEs to assist them in leveraging the Health Neighborhood and Community to address members' social and other health needs, including increasing access to timely and appropriate Medicaid services and benefits, and the promotion of healthy communities that can positively impact the conditions in which members live.
- Establish and strengthen relationships among its network providers and the Health Neighborhood in the region by supporting existing collaborations and facilitating the creation of new connections and improved processes, while avoiding duplication of existing local and regional efforts.
- Participate in and align its activities with advisory groups, existing programs and statewide initiatives designed to strengthen the health care system, including:

- ✓ The Cost Collaborative
- ✓ Managed Service Organizations (MSOs)
- ✓ Colorado Crisis System
- ✓ State Innovation Model (SIM)
- ✓ Colorado Opportunity Framework
- ✓ Comprehensive Primary Care Initiative (CPC+)
- ✓ Community Living Advisory Group
- ✓ Benefits Collaborative
- ✓ Pharmacy and Therapeutics Committee and Drug Utilization Review Board
- ✓ Utilization Management Vendor

C. Other Relevant Contractual Requirements

In addition to being explicitly required to seek collaborations with hospitals on the HTP and within the community more generally, RAEs have other requirements that are not directly connected to the HTP but align well with the program. This includes data collection requirements and programming requirements that are well-aligned with HTP priorities.

The rest of this appendix outlines RAE requirements that are not specific to HTP or community engagement but may serve as resources as hospitals plan for and implement their HTP initiatives.

Data Sharing and Collection

RAEs are responsible for facilitating health data sharing among providers in the Health Neighborhood and collecting and maintaining a variety of data sets, making them ideal partners in providing data to inform hospitals' HTP planning during the CHNE process and environmental scan. Hospitals may also look to leverage these resources and data for their HTP projects. RAEs are responsible for acquiring, processing or maintaining the following data:

- Attribution and assignment information for all members in their region
- Network adequacy information for its Primary Care Medical Providers (PCMP) and Behavioral Health Network:
  - ✓ Patient load in the provider network and case load standards
  - ✓ How the RAEs maintain and monitor a network of appropriate providers
  - ✓ How the RAEs ensure that network providers provide access for Medicaid enrollees with physical or mental disabilities.
  - ✓ Number of network providers by provider type and areas of expertise particularly:
    - Adult primary care providers
    - Pediatric primary care providers
    - OB/GYNs
    - Adult mental health providers
    - Pediatric mental health providers
    - Substance use disorder providers
    - Psychiatrists
    - Child psychiatrists
    - Psychiatric prescribers
    - Family planning providers

- ✓ Number of network providers accepting new Medicaid members by provider type.
- ✓ Geographic location of providers in relationship to where Medicaid members live.
- ✓ Cultural and language expertise of providers.
- ✓ Number of providers offering after-hours and weekend appointment availability to Medicaid members.
- ✓ Performance meeting timeliness standards.
- ✓ New providers contracted during the quarter.
- ✓ Providers that left the network during the quarter.

- A regional resource directory listing all community resources available to members, and a PCMP and behavioral health provider directory
- Quality and health needs data, including:
  - ✓ Member responses to the Health Needs Survey
  - ✓ ACC performance measures
  - ✓ Member experience data, including the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) for both adults and children.
  - ✓ CAHPS Experience of Care and Health Outcomes (ECHO) survey for behavioral health
  - ✓ Overutilization and underutilization of services
  - ✓ Quality and appropriateness of care furnished to members

Programming

The following programming requirements for RAEs may provide opportunities for hospitals to partner with or contribute to RAE initiatives as part of their HTP initiatives:

- Implement programs and/or procedures to reduce unnecessary utilization of the emergency department for members residing in nursing facilities and members receiving end of life care.
- Implement programs to address identified barriers to provider participation in the Health Neighborhood and to support the efficient use of specialty care resources
- Develop and/or provide cultural and disability competency training programs, as needed, to network providers
- Develop programs and materials that complement Department initiatives and other activities to assist members in effectively utilizing Medicaid benefits and to support members in becoming proactive participants in their health and well-being.
- Implement initiatives to build local communities to optimize member health and well-being, particularly for those members with complex needs that receive services from a variety of agencies.
- Incorporate evidence-based practices, and promising local initiatives that align with the Colorado Opportunity Project's Framework endorsed interventions (see https://www.colorado.gov/pacific/hcpf/colorado-opportunity-project) in the development of a Population Health Management Plan
- Partner with the Department in administering the Client Over-Utilization Program (COUP)
- Utilize admit/discharge/transfer data to improve transitions of care
- Activities to increase regional provider enrollment in Medicaid activities to increase regional provider Medicaid member panels recruitment efforts and training for utilization of electronic consultation

- Implement and maintain an ongoing comprehensive quality assessment and performance improvement program that aligns with the Department's Quality Strategy and include population health objectives as well as clinical measures of quality care
- Have a minimum of two Performance Improvement Projects chosen in collaboration with the Department: one that addresses physical health and may include behavioral health integration in physical health, and one that addresses behavioral health and may include physical health integration into behavioral health.

Care Coordination

Finally, as the entities responsible for connecting Medicaid members to care, RAEs are required to ensure that care coordination is accessible to members at the point of care whenever possible, including during transitions in care. Hospitals may have opportunities to align with these efforts as they plan initiatives within the care coordination and care transitions for vulnerable populations priority area:

- Ensure that care coordinators in the RAE's network reach out and connect with other service providers and communicate information appropriately, consistently and without delay.
- Ensure that all care coordination, including interventions provided by network providers and subcontractors, meet the needs of the member.
- Designate staff persons to serve as single point of contact with the different systems and settings.
- Provide specific guidance to care coordinators about each setting, regarding how to identify members in the system/setting; how to provide care coordination services in the system/setting; and how to communicate with contact people in the system/setting to plan transitions, coordinate services, and address issues and member concerns.
- Participate in special workgroups created by the Department or other state agencies to improve services and coordination of activities for the populations served by multiple systems.
- For members with intellectual and developmental disabilities who require services for conditions other than a mental health or substance use disorder, assist the member in locating appropriate services.
- For members with substance use disorders who require services not covered by Medicaid, coordinate care with the state's Managed Service Organizations.
- Establish arrangements with the Colorado Crisis Services vendors for the coordination of follow-up care for Medicaid members who accessed crisis services.
- Assist care coordinators within the network with bridging multiple delivery systems and state agencies.
- Ensure that Care coordination tools, processes, and methods are available to and used by network providers
- Possess and maintain an electronic care coordination tool
- Assist any member who contacts the RAE, including members not in the region who need assistance with contacting his/her PCMP and/or RAE
- Collaborate with the Healthy Communities contractors in the region for onboarding members to Medicaid and the Accountable Care Collaborative. Healthy Communities will have contracted responsibilities to onboard children and their parents through outreach, navigation support of Medicaid benefits, and education on preventive services.

- ✓ Refer child members and their families to Healthy Communities for assistance with finding Community resources and navigating child and family services.
- ✓ Onboard to Medicaid and the Accountable Care Collaborative all other members who are not being contacted by Healthy Communities.

Communication and Staffing

As the Department and hospitals begin to connect with the RAEs, it will be useful to be aware of and identify in requests the following key positions that RAEs are required to employ:

- Program Officer: serves as the primary point of contact
- Chief Financial Officer: accountable for the administrative, financial, and risk management operations of the organization, to include the development of a financial and operational strategy, metrics tied to that strategy, and the ongoing development and monitoring of control systems designed to preserve company assets and report accurate financial information.
- Chief Clinical Officer: defines the overall clinical vision for the organization; provides clinical direction to network management, quality improvement, utilization management and credentialing divisions; participates in strategy development and the design and implementation of innovative clinical programs and interventions with the Health Neighborhood and Community.
- Quality Improvement Director: accountable for development and implementation of quality improvement programs, and all aspects of measuring and assessing program outcomes.
- Health IT and Data Director: facilitates data sharing among the Contractor, the state, and Network Providers; assists Network Providers to maximize the use of EHRs and Health Information Exchange.
- Utilization Management Director: leads and develops the utilization management program and manages the medical review and authorization process; analyzes and monitors utilization trends, identifies problem areas and recommends action plans for resolution.

Appendix II: Community Inventory Tool[3]

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

Clinical and Behavioral Health Providers

Provider or Agency	Transitional Care Services [Examples]	Yes	No
Community health centers, federally qualified health centers	[ability to accept new patients; timely posthospital follow-up; co-located social work, nutritional, pharmacy services, etc.]	❑	❑
Accountable care organization with care management or transition care	[high-risk-care management, transitional care to reduce readmissions, etc.]	❑	❑
Medicaid managed care organizations	[high-risk-care management, social work, wraparound services, etc.]	❑	❑
Program of All-inclusive Care for the Elder (PACE), Senior Care Options (SCO), Duals Demonstration providers	[capitated or risk-bearing providers focused on providing whole-person care to improve quality and reduce costs]	❑	❑
Medicaid health homes	[engagement, outreach, tiered care management; eligibility based on chronic and behavioral health conditions]	❑	❑
Multiservice behavioral health centers, including behavioral health homes	[prioritized posthospital follow-up; availability for new patients; co-located support services, etc.]	❑	❑
Behavioral health providers	[accepting new patients, prioritizing posthospital follow-up, etc.]	❑	❑
Substance use disorder treatment providers	[effective processes for linking patients from acute care to substance use disorder treatment]	❑	❑
Heart failure, chronic obstructive pulmonary disease (COPD), HIV, dialysis, or cancer center clinics	[urgent appointments for symptom recurrence, protocol-driven ambulatory management, social work, education, etc.]	❑	❑
Pain management or palliative care	[symptom management over time, often with behavioral health specialists and social workers, education, etc.]	❑	❑
Physician/provider home visit service	[timely post discharge in home evaluation, coordination with primary care, specialists, pharmacy, home health, etc.]	❑	❑

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

Provider or Agency	Transitional Care Services [Examples]	Yes	No
Skilled nursing facilities	[onsite providers, warm handoffs, joint readmission reviews, INTERACT (Interventions to Reduce Acute Care Transfers) processes, transitional care from skilled nursing facility to home, etc.]	❑	❑
Home health agencies	[warm handoffs, joint readmission reviews, front-loaded home visits, behavioral health clinical expertise, etc.]	❑	❑
Hospice	[warm handoffs, joint readmission reviews, same-day home visits, etc.]	❑	❑
Adult day health	[daily clinical, nutritional, medication management, socialization, etc.]	❑	❑
Public health nurses	[home visits, outreach, education, clinical coordination, etc.]	❑	❑
Pharmacies	[bedside delivery, home delivery, medication therapy management, affordability counseling, blister packs, etc.]	❑	❑
Durable medical equipment	[same-day delivery; 30-day transitional care monitoring, education services, etc.]	❑	❑
Other			

Social Services

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

Appendix III: Hospital Care Transitions Activities Inventory Tool[4]

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

Readmission Activities/Assets

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

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

TRANSITIONAL CARE DELIVERY IMPROVEMENTS	For Which Patients?
❑ Assess "whole-person" or other clinical readmission risk	
❑ Identify the "learner" or care plan partner to include in education and discharge planning	

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

TRANSITIONAL CARE DELIVERY IMPROVEMENTS	For Which Patients?
❑ Use clinical pharmacists to enhance medication optimization, education, reconciliation	
❑ Use "teach-back" to improve patient/caregiver understanding of information	
❑ Schedule follow-up appointments prior to discharge	
❑ Conduct warm handoffs to post-acute and/or community "receivers"	
❑ Conduct post discharge follow-up calls (for patient satisfaction or follow-up purposes)	
❑ Other:	

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

CROSS-CONTINUUM PROCESS IMPROVEMENT COLLABORATIONS WITH:	For Which Patients?
❑ Skilled nursing facilities	
❑ Medicaid managed care plans	
❑ Community support service agencies	
❑ Behavioral health providers	
❑ Other:	

Appendix IV: HTP Framework

Focus Area	Goals and Outcomes	Policy Topics	Potential Approaches
High Utilizers	Reduce Avoidable Utilization	Address Complex Care for targeted populations without co-occurring mental health diagnoses	• ED and Hospital Care Transitions • Address Chronic Illness • Mental Health and Substance Abuse • Chronic Pain Management • Coordination of Care • Discharge Planning and Follow-Up • Care Management • ED Utilization • Other
	Improve Quality of life		
	Improve Patient Experience		
	Reduce Burden of Chronic Illness	Address complex care for targeted populations with mental health diagnoses	
	Increase Patient Engagement		

Focus Area	Goals and Outcomes	Policy Topics	Potential Approaches
Vulnerable Populations	Improve Clinical and Quality Outcomes	Address maternal health, perinatal care, and improved birth outcomes	• Support Health of New and Expectant Mothers • Improve Coordination of Care • Elderly/End of Life Care • Address Social Determinants of Health • Address Homelessness Health • Outreach and Community Care • Prevention • Perinatal Care Coordination to Reduce Poor Birth Outcomes • Other
	Increase Patient Engagement		
	Improve Patient Experience	Address care coordination and care transitions for vulnerable populations	
	Improve and Coordinate Processes of Care		

Focus Area	Goals and Outcomes	Policy Topics	Potential Approaches
Behavioral Health and Substance Abuse	Improve Access to Care	Address and alleviate the opioid crisis in Colorado	• Medication Counseling • Opioid RX Reduction • Opioid Alternatives • Team Based Care • Withdrawal Management and Enhanced Abstinence Services • Outreach and Treatment Programs • Embedded Behavioral Health • Screening Programs • Other
	Coordinate Care		
	Integrate Physical and Mental Health		
	Reduce Overdoses and Deaths	Address a community-Specific BH/SUD issue identified during the CHNE process	
	Reduce Excess Utilization		

Focus Area	Goals and Outcomes	Policy Topics	Potential Approaches
Clinical and Operational Efficiencies	Reduce Waste	Resource Stewardship	• ED Care Coordination • Care Transitions • Level of Care Assessments in the ED • Optimize Inpatient Utilization • Improved Data Sharing • Reducing and Addressing Potentially Avoidable Costs/Complications • E-Consults and Telehealth Visits • Care Delivery Options Appropriate for Lower Cost Settings • Other
	Reduce Potentially Avoidable Costs/Complications	Hospital-Specific Expenses	
	Reduce Expenses	Community Outreach and Care	

Focus Area	Goals and Outcomes	Policy Topics	Potential Approaches
Community Development Efforts to Address Population Health and Total Cost of Care	Reduce Total Cost of Care	Community Outreach and Support	• Address Social Determinants of Health • Active Outreach and Screenings • Resource Stewardship • Diabetes Prevention • Reproductive/Sexual Health • Tobacco Cessation • Nutrition and Wellness • Community-Wide Collaboration • Other
	Address Social Determinant of Health	Screenings and Assessments	
	Improve quality of Care	Care Delivery and Management	
	Improve Health Status		