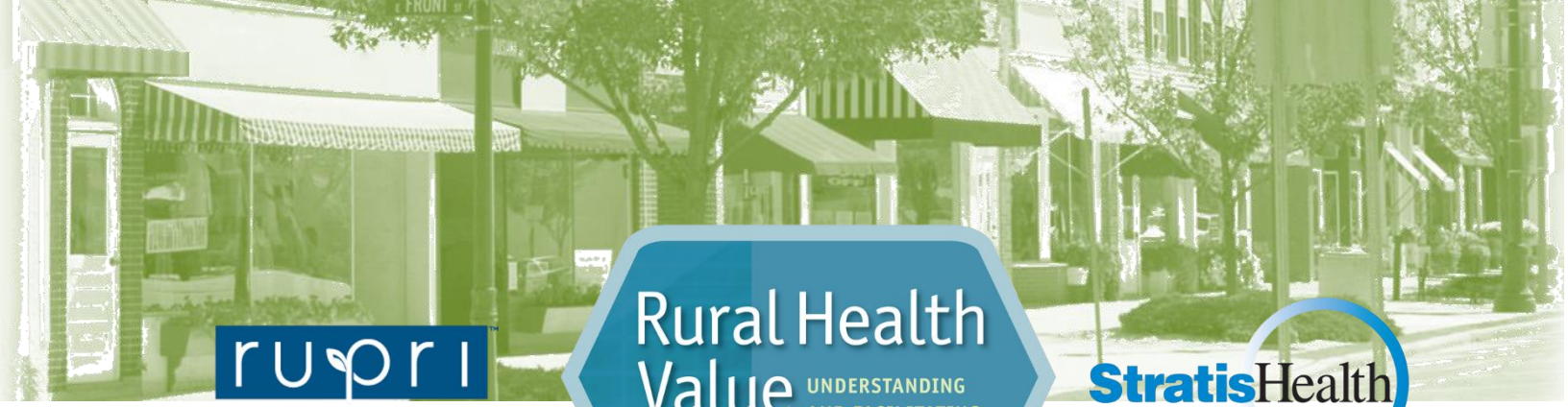

RURAL POLICY RESEARCH INSTITUTE
Center for Rural Health Policy Analysis

Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

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Rural Innovation Profile

Rural Hospital Experiences in the Colorado Hospital Transformation Program

What: All hospitals in Colorado are participating in the Colorado Hospital Transformation Program (CO HTP), a 5-year program that ties Medicaid supplemental payments to hospitals' ability to meet performance targets.

Why: To improve health care outcomes, equity, and access and decrease health care costs.

How: The CO HTP leverages state and national Medicaid funding to drive change that can lead to improved patient outcomes, quality, equity, and access for all patients and prepare Colorado hospitals for future value-based care and payment models.

This profile summarizes experiences of three rural Colorado hospital participants: Lincoln Community Hospital in Hugo, Melissa Memorial Hospital in Holyoke, and Prowers Medical Center in Lamar.

Summary

- The CO HTP is a mandatory, statewide, value-based care initiative that is structured to encourage hospitals to meet and address State goals of improving care and lowering costs, but with the flexibility to support community relevant initiatives, approaches, and measures.
- CO HTP requires and supports community and population health planning by rewarding community and patient focused, hospital-led, strategic initiatives.
- Program requirements are adjusted for Critical Access Hospitals and supplemental support funds are available for low revenue rural hospitals.
- One of the challenges faced by rural hospitals participating in the program is addressing and overcoming issues with costly, inefficient, ineffective electronic health records.
- It is important to acknowledge the resource challenges of rural hospitals when requiring them to fully engage in complex programs focused on quality improvement, payment reform, and community-based care coordination.

OVERVIEW

The Colorado Health Transformation Program (CO HTP) is a 5-year program being implemented in all Colorado general acute care and pediatric hospitals, including Critical Access Hospitals (CAHs). The goals of the program are to: 1) improve patient outcomes through care redesign and integration of care across settings, 2) improve the performance of the care delivery system by ensuring appropriate care in the appropriate setting, 3) lower Health First Colorado (Colorado's Medicaid program) costs through reductions in avoidable hospital utilization and increased effectiveness and efficiency in care delivery, and 4) accelerate operational and systems readiness for value-based payment among participating organizations.[1]

Using structured activity and quality measures, hospitals work with their communities to determine the interventions and measures that will best reflect their priorities and effort, meet local needs, improve outcomes, and decrease costs. All Colorado hospitals are participating in the CO HTP. This report summarizes the experiences of three CAHs to provide insight into how the CO HTP is impacting rural hospitals.

BACKGROUND

The Colorado HTP was established as a 5-year initiative by the Colorado legislature in 2019. Although scheduled for launch in April 2020, the Covid-19 global pandemic delayed the start of Program Year-1 (PY1) to October 1, 2021, with Program Year-5 (PY5) concluding September 30, 2026. The HTP has three phases for measuring progress towards reaching milestones: 1) Planning and Implementation Phase which focuses on completing all preliminary requirements, 2) Performance Phase which focuses on advancing performance measures that impact payments, and 3) Continuous Improvement Phase which focuses on quality improvement.

Eligible hospitals that do not participate in the CO HTP will have the entirety of their supplemental Medicaid payments withheld. To participate in the program, hospitals were required to submit a program application and an implementation plan. Plans can be amended as needed during quarters 2 and 4 of each year. As stated in the CO HTP Implementation Plan and Template Milestones Requirements, the implementation plan details strategies and steps to implement interventions that address the six program priority areas with activities focused both on Medicaid beneficiaries and the broader community as a whole: 1) care transitions; 2) complex care management for target populations; 3) behavioral health and substance abuse disorder coordination; 4) maternal health, perinatal care, and improved birth outcomes; 5) social determinants of health; and 6) total cost of care.

[1] Colorado Hospital Transformation Program | Colorado Department of Health Care Policy & Financing

Key components of the first program year were planning and community engagement. Each hospital was required to submit a program plan which included selection of quality measures, interventions, and milestones. Each year, hospitals are required to implement Community and Health Neighborhood Engagement (CHNE). In Program Year-1 this included conducting a community environmental scan of services and gaps in services, demographics, resources, health status and health issues, as well as other areas. Throughout all five years, hospitals are also required to: 1) regularly meet with community partners, 2) convene community advisory committee meetings to assess community needs, identify and modify CO HTP priorities, plan, and further develop and foster community awareness and collaboration, 3) hold a public forum – at least once a year – to share CO HTP work with the community and get feedback on what patients would like to see done differently, and 4) participate in annual statewide CO HTP Learning Symposiums. The first HTP Learning Symposium, held in June 2023, focused on sharing experiences and tools and discussing best practices, processes, data, and community engagement.

Beginning in CO HTP Program Year-2, hospitals can earn (or lose) at-risk supplemental Medicaid funding through quarterly reporting of data for the quality measures they selected and on interventions and milestones. While most CO HTP requirements are the same for all hospitals, a few are unique to CAHs. For example, CAHs can report a minimum of six quality measures versus eight quality measures (some CAHs have selected to report more) and CAHs have a lower percentage of at-risk Medicaid funding. In addition, a complementary Rural Support Fund with $12 million in annual funds ($60 million total for five years) was set aside to provide additional financial support to 23 of the most at-risk rural hospitals. Funding is split equally among the qualifying hospitals who must submit an annual attestation form requesting payment. Rural Support Funding can be used to increase hospitals' technical capacity and/or to operationalize hospitals' strategic plans towards advancing their preparation for future value-based or alternative payments. Meanwhile for all CO HTP hospitals, payment adjustments are based on a mix of pay for reporting and activity, achievement of project milestones, and performance or improvement on outcome measures as described in the HTP-Implementation Plan Template and Milestone Requirements.

There are 76 hospitals in CO HTP eligible to earn back at-risk supplemental Medicaid dollars for meeting patient and community needs, improving care and outcomes, and decreasing costs. As stated in the Hospital Transformation Program Scoring Framework (July, 24, 2023), the schedule for at-risk Medicaid funding for CAHs is as follows:

- During the Program Application period, 1.5 percent of payments are at-risk contingent on the hospital application.
- In PY1, 2.5 percent of payments will be at-risk, with 1.5 percent at-risk for the implementation plan and 1 percent at risk for timely reporting.

- In PY2, 6 percent of payments will be at-risk, with 4 percent at-risk for meeting major project milestones, and 2 percent at risk for timely reporting.
- In PY 3, 13 percent of payments will be at-risk, with 8 percent at-risk for meeting major project milestones, 3 percent at risk for performance on measures and 2 percent at risk for timely reporting.
- In PY4, 13 percent of payments will be at-risk, with 11 percent at risk for performance on measures and 2 percent at risk for timely reporting.
- In PY5, 22 percent of payments will be at-risk, with 12 percent at risk for performance on measures and 2 percent at risk for timely reporting, and 8 percent at risk contingent on submission of a sustainability plan.

Hospitals can earn back the at-risk dollars by achieving or exceeding the targets set for each measure and intervention they selected in their application. The targets are based on historical performance, national benchmarks, and improvement rates. Hospitals can also earn bonus points for exceeding the targets or demonstrating high performance.

CAH EXPERIENCE WITH THE CO HTP

Three CAHs were interviewed to gain preliminary insights into CO HTP planning, impacts on cost and quality, successes, challenges, and next steps. The CAHs interviewed were Lincoln Community Hospital, in Hugo, Melissa Memorial Hospital in Holyoke, and Prowers Medical Center in Lamar. All three CAHs indicate they are participating in CO HTP because it is required, but also because of the opportunity to impact patient outcomes, quality of care, community engagement, and to build capacity for value-based payment programs. Additionally, all three CAHs agree they would participate in the CO HTP even if it was a voluntary program.

Planning and Community Engagement

Program Year-1 of CO HTP focused on planning and community health and all three CAHs report this work has improved patient, community, and statewide partnerships, knowledge of services, coordination, and planning. All CAHs agree the CHNE planning and community networking requirements expanded their teams' knowledge of the availability (or the lack thereof) of community services and programs, community knowledge of hospital services, and the communication and coordination between services. Kevin Stansbury, Lincoln Community Hospital CEO, reports CHNE planning is an area where CAHs can thrive and do well because, "We know our communities and our patients," and community engagement is key to CAH survival. Through the community health planning process, Lincoln Health identified their need for a guide listing community resources. The result is currently in hard copy and will be distributed through community organizations and to patients. They plan to host the guide on the hospital's website.

The three CAHs also attribute increased regional and statewide planning and collaboration to CO HTP. This is occurring through the statewide HTP Learning Symposium as well as through networks. For example, the quality teams of the Eastern Plains Consortium, a network of 11 hospitals including Lincoln Community Hospital and Melissa Memorial Hospital, meet virtually every Monday. The meetings have representation from state level CO HTP team members and, together with the network QI staff, they develop and share their CO HTP plans, strategies, successes, and challenges. When hospitals' CO HTP planning began, the network hospitals agreed to work on the same measures which allows them to aggregate their data into a network report so they can work together on improvement. This collaboration has evolved to include sharing staff across a few of the hospitals. Staff sharing started with QI staff and has broadened to include responsibilities for medical staff credentialing as well as clinical staff and others. Not only has the staff sharing filled needs and provided expertise to those in need but the staff being shared are more effectively engaged in work at the top of their skill level/scope of practice impacting both staff satisfaction and costs.

"We got innovative, we got together, and we shared the angst to get it done."

Michael Hassell, CEO, Melissa Memorial Hospital

Although planning and community engagement were reported as some of the CAHs' greatest successes thus far, challenges also exist. An initial challenge was CO HTP timing as it was set to launch at the start of the Covid-19 pandemic. Hospitals submitted their CO HTP applications in 2019, then had to pivot to address urgent Covid-19 issues. During the year between CO HTP planning and implementation there was a lot of hospital staff turnover. Therefore, some of the plans did not align with the views and priorities of new staff and care delivery systems after Covid-19.

Fulfilling the requirements of CHNE has also been challenging, depending on community partners and relations and organizational structures that may or may not need to be created. For example, Prowers Medical Center finds meetings with community partners to be easy and ongoing; but community advisory committee meetings are more demanding because there was no established forum, and it requires an investment of attention from community leaders in areas where they previously may not have had a voice.

Quality of Care

The three CAHs report CO HTP provides the funding, tools, and measures that enhance their quality initiatives overall and encourages them to showcase efforts and successes that were already underway and being developed. Some of the QI measures they selected are new to their improvement efforts; however, when possible, they selected measures already being used/identified as a priority, and/or required by another payment program. This strategic approach allows their limited number of staff to focus on a more focused set of interventions. Each of the hospitals report information to the state quarterly, but internal QI measurement and reporting is constant. CO HTP's required QI reporting has impacted all staff, leading to staffs' education, growth, and commitment to QI.

"CO HTP has removed the blinders regarding the importance of quality improvement throughout our organizations."

Tina Sandoval, Chief Clinical Officer, Prowers Medical Center

With Year-2 of CO HTP implementation underway, the three CAHs report they are focusing on learning more about population health, implementing and using additional information technology so they can abstract the quality data needed to measure and report, and learning more about the use and value of data analytics. All three CAHs report significant issues with their electronic health records (EHRs). Challenges with data access, use, and reporting contribute to higher costs, and limited data analytics hamper their ability to support CO HTP implementation plans. These issues are not new, and they are compounded by a lack of health information technology and data analytics experts in rural communities. Additionally, EHR vendors are not inclined to support metrics that are not federal requirements. To try and overcome some of the EHR challenges, the hospitals are developing workarounds such as collaborating, purchasing data analytics software, and looking at ways to move to a different EHR. For those looking to move to a different EHR, cost and staff time are barriers, and some of the EHR vendors will not work with small rural hospitals unless they are part of a larger system or partnering with a significantly larger hospital.

"The dream of the EHR has not been realized."

Michael Hassell, CEO, Melissa Memorial Hospital

Amber Rider, Prowers Medical Center, reports CO HTP is contributing to significant process changes in the hospital, between departments, and in the delivery system as a whole. For example, one of the measures they are working on is collaborative discharge planning and care coordination for patients with substance use disorder and/or patients with a mental illness. Prowers Medical Center doesn't have staff trained to do this work. Therefore, they have implemented a new process using warm handoffs with community partners to ensure patients are connecting with the appropriate care providers.

Prowers Medical's quality department also completed a 6-session online training, The Communities of Excellence Training – Baldridge. They will be using this training to advance their CHNE activities.

"CO HTP requires that we screen for our patients needs and we take it one more step by connecting them to services and resources to get those needs met."

Amber Rider, Director of Quality and Patient Safety, Prowers Medical Center

Melissa Memorial Hospital is leveraging its Veterans Community Outreach Program to address health-related social needs. For this program, the hospital hosts a weekly, 3- to 4-hour coffee chat that includes coffee, breakfast, and conversation. Veterans (and anyone else who wants to join) are encouraged to gather and share what is going on in their lives that impacts their health and wellbeing. The food costs for the program are funded through staff donations that are made when staff wear jeans to work on Wednesdays. Coffee chats are an opportunity to provide outreach and address issues related to loneliness, suicide, health, and wellness.

"None of this will change until we can find a way to influence people's behaviors."

Kevin Stansbury, CEO, Lincoln Community Hospital

Although they have had successes, the CAHs also expressed various challenges. For example, Kevin Stansbury at Lincoln Community Hospital noted, "When talking about health equity and disparities in rural areas, there tends to be more focus on socio-economic barriers. Asking questions related to social drivers of health can be very difficult. They [patients] don't want to answer those questions." He added, "Patients out here will avoid care until they absolutely have to go to the doctor." Regardless of health care provider engagement and support, individual patient abilities, resources, and choices relating to managing their conditions and following up can be an ongoing challenge. Another ongoing leadership challenge is creating and maintaining buy-in from staff to ensure there is follow-through on initiatives and measures.

Health Care Costs

Although decreasing health care costs is a CO HTP priority, all three CAHs agree it is too early to determine any measurable impact. Factors that will likely contribute to costs are the additional "bureaucratic layers" that were established to manage the funding, patient behaviors, rising workforce costs, and inconsistent and often limited access to wrap-around services in rural areas that heavily influence social determinants of health. Kevin Stansbury talked about the challenges of decreasing costs and the difference between lowering costs per patient and lowering costs overall. This can be particularly challenging for rural hospitals because of low

"Anyone who understands health economics knows that until we change the incentives for how care is provided, we're not going to reduce the overall cost of care."

Kevin Stansbury, CEO, Lincoln Community Hospital

patient volume, broad service areas, regional poverty, high prevalence of community members with chronic conditions, limited transportation options, and inadequate access to behavioral health, specialty providers, and community services/supports.

Prowers Medical Center reports they are working on cost reductions through avoidable hospital utilization, focusing on two measures: all cause readmissions and chronic conditions readmissions. They had a low readmissions rate overall but as they started rolling out interventions, they identified opportunities for improvement which led to establishing a patient integrated collaborative care committee that includes case managers, a care transitions specialist, and community partners. Meeting weekly, they talk about the status and needs of patients who will be discharged, and how they can work together to meet these needs.

"CO HTP has pushed our readiness forward to make sure we have positioned ourselves well so we're not only ready for HTP but all other payment programs we participate in."

Amber Rider, Director of Quality and Patient Safety, Prowers Medical Center

CO HTP removed the co-pays for Medicaid beneficiaries, and hospitals are waiting to see if this impacts Medicaid beneficiary patient behavior; however, hospitals' CO HTP efforts impact all patients as hospitals have the same policies and procedures for patients, regardless of payor. All three CAHs report they have received enhanced payments through CO HTP. They celebrate this success with their teams and report this helps maintain momentum and engagement.

Next Steps: Since Program Year-2 is just getting underway, the three CAHs will continue to focus on engaging and improving relations with patients and community partners, learning from network members and other hospitals around the state, educating staff and building staff commitment to QI, mining data, working with EHR vendors and other software vendors to use data better, and many other activities. All three CAHs report they will be working to educate patients disenrolled from Medicaid (following the end of the public health emergency) regarding reenrollment opportunities. This is an important step to help ensure eligible patients retain coverage, recognizing the impact that coverage has on health care access and behavior and the alignment with the CO HTP program incentives and structure. The CAHs also report they are always preparing for the next CO HTP reporting event and are finalizing and implementing interventions.

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