



# HOSPITAL TRANSFORMATION PROGRAM COMMUNITY AND HEALTH NEIGHBORHOOD ENGAGEMENT

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## *MIDPOINT REPORT*

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## Instructions and Timeline

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

The State will be reviewing Midpoint Reports to ensure:

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

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

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

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



## Contact Information

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

Hospital Name: UCHealth Highlands Ranch Hospital

Hospital Medicaid ID Number: \_\_\_\_\_

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

Hospital Address: 1500 Park Central Drive

Highlands Ranch, CO 8021

Hospital Executive Name: Barbara Carveth

Hospital Executive Title: Chief Financial Officer

Hospital Executive Address: 12401 E 17th Ave, Mail Stop F448

Aurora CO 80045-2603

Hospital Executive Phone number: 720-848-7773

Hospital Executive Email Address: Barbara.Carveth@uchealth.org

Primary Contact Name: Roberta Capp

Primary Contact Title: Medical Director Care Transitions

Primary Contact Address: 12401 E 17 th Ave, Aurora CO 80045

Primary Contact Phone Number: 720-848-4398

Primary Contact Email Address: Roberta.capp@uchealth.org

Secondary Contact Name: Kellee Beckworth

Secondary Contact Title: Sr. Project Manager

Secondary Contact Address: 12401 E 17 th Ave, Aurora CO 80045

Secondary Contact Phone Number: 720-848-6525

Secondary Contact Email Address: Kellee.Beckworth@uchealth.org



## Engagement Update

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

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

Organization Name	Organizational Contact	Organization Type	Engagement Activity	Connection to any specific HTP priority populations and / or project topics, as applicable
All Health Network	Cynthia Grant	Mental Health Center	Partnership	Vulnerable Populations/SUD/Behavioral Health
CHA Opioid Summit	Ashley Baker	Consumer Advocates/Advocacy Organizations	Involvement	Behavioral Health
Colorado Health & Human Services, Refugee Department	Carol Tumaylle	Community organization addressing social determinants of health	Partnership	Refugee Population
Colorado Health Institute	Ann Loeffler	Community organization addressing social determinants of health	Partnership	Social Determinants of Health
Colorado Health Literacy Coalition	Dana Abbey, Angela Brega	Community organization addressing social determinants of health	Partnership	Social Determinants of Health
Colorado Prevention Alliance	Lauren Ambrozic	Health Alliance	Involvement	Vulnerable Populations (Social Determinants of Health)
MCPN	Heather Logan	FQHC	Partnership	Vulnerable Populations (Transition of Care for pregnant women)
RETAC	Valorie Peaslee	RETACs	Partnership	All
RETAC-Denver Metro	Shirley Terry	RETACs	Partnership	All



Organization Name	Organizational Contact	Organization Type	Engagement Activity	Connection to any specific HTP priority populations and / or project topics, as applicable
Vivage	Heather Terhark	LTSS	Partnership	All

**The following community outreach was done by the Colorado Health Institute:**

Organization Name	Organizational Contact	Organization Type	Engagement Activity	Connection to any specific HTP priority populations and / or project topics, as applicable
Adams County Health Alliance	Attendee list not available	Health Alliance	Facilitated Discussion	Social supports, care transitions, health data infrastructure, advocacy
Douglas County Health Alliance	Attendee list not available	Health Alliance	Facilitated Discussion	Social supports, care transitions, health data infrastructure, advocacy
Jefferson County Health Alliance	Attendee list not available	Health Alliance	Facilitated Discussion	Social supports, care transitions, health data infrastructure, advocacy
Adams County Health Alliance	Meghan Prentiss	Health Alliance	Focus Group	Social supports, care transitions, health data infrastructure, advocacy
AllHealth Network	Cynthia Grant	Community Mental Health Center	Focus Group	Behavioral health, substance use
Aurora Health Alliance	Mandy Ashley	Health Alliance	Focus Group	Social supports, care transitions, health data infrastructure, advocacy
Boulder County Health Improvement Collaborative	Morgan McMillan	Health Alliance	Focus Group	Social supports, care transitions, health data infrastructure, advocacy
Broomfield FISH	Dayna Scott	Community organizations addressing social determinants of health	Focus Group	Social supports
Center for African American Health	Deidre Johnson	Community organizations addressing social determinants of health	Focus Group	Social supports
Center for Health Progress	Christopher Klene	Community organizations addressing social determinants of health	Focus Group	Social supports



Organization Name	Organizational Contact	Organization Type	Engagement Activity	Connection to any specific HTP priority populations and / or project topics, as applicable
City and County of Denver	Tristan Sanders	Local Public Health Agency	Focus Group	Population health, maternal child health, social determinants of health, behavioral health
Clinica Family Health	Simon Smith	Federally Qualified Health Centers	Focus Group	Access, primary care, social determinants, behavioral health, mothers and infants, care coordination
Clinica Tepeyac	Jim Garcia	Federally Qualified Health Centers	Focus Group	Access, primary care, social determinants, behavioral health, mothers and infants, care coordination
Colorado Access	Daniel Obarski, Molly Markert	RAE	Focus Group	High utilizers, total cost of care, coordination, service availability, social determinants of health, behavioral health
Colorado Community Health Alliance	Hanna Thomas, Jessica Rink	RAE	Focus Group	High utilizers, total cost of care, coordination, service availability, social determinants of health, behavioral health
Denver Health and Hospital Authority	Simon Hambidge	Federally Qualified Health Centers	Focus Group	Access, primary care, social determinants, behavioral health, mothers and infants, care coordination
Denver Public Health	Jessica Forsyth, Kellie Teter	Local Public Health Agency	Focus Group	Population health, maternal child health, social determinants of health, behavioral health
Douglas County Health Alliance	Wendy Nading	Health Alliance	Focus Group	Social supports, care transitions, health data infrastructure, advocacy
High Plains Community Health Center	Eric Niedermeyer	Federally Qualified Health Centers	Focus Group	Access, primary care, social determinants, behavioral health, mothers and infants, care coordination
Hunger Free Colorado	Sandy Nagler, Brett Reeder	Community organizations addressing social determinants of health	Focus Group	Social supports
Jefferson Center for Mental Health	Don Bechtold	Community Mental Health Center	Focus Group	Behavioral health, substance use
Jefferson County Public Health	Kelly Kast, Melissa Palay	Local Public Health Agency	Focus Group	Population health, maternal child health, social



Organization Name	Organizational Contact	Organization Type	Engagement Activity	Connection to any specific HTP priority populations and / or project topics, as applicable
				determinants of health, behavioral health
Marillac Clinic	Kay Ramachandran	Federally Qualified Health Centers	Focus Group	Access, primary care, social determinants, behavioral health, mothers and infants, care coordination
Mile High Health Alliance	Dede de Percin, Karen Trautman, Alyssa Harrington	Health Alliance	Focus Group	Social supports, care transitions, health data infrastructure, advocacy
Mountain Family Community Health Center	Ross Brooks	Federally Qualified Health Centers	Focus Group	Access, primary care, social determinants, behavioral health, mothers and infants, care coordination
Peak Vista Community Health Center	Pam McManus	Federally Qualified Health Centers	Focus Group	Access, primary care, social determinants, behavioral health, mothers and infants, care coordination
Sheridan Health Services	Erica Shierer	Federally Qualified Health Centers	Focus Group	Access, primary care, social determinants, behavioral health, mothers and infants, care coordination
Signal Behavioral Health	Heather Dolan	Managed Service Organization	Focus Group	Behavioral health, substance use
STRIDE Community Health Center	Ben Niederman	Federally Qualified Health Centers	Focus Group	Access, primary care, social determinants, behavioral health, mothers and infants, care coordination
Sunrise Community Health Center	Mitzi Moran	Federally Qualified Health Centers	Focus Group	Access, primary care, social determinants, behavioral health, mothers and infants, care coordination
Tri-County Health Department	Emma Goforth, Heather Baumgartner	Local Public Health Agency	Focus Group	Population health, maternal child health, social determinants of health, behavioral health
Colorado Coalition for the Homeless	Brian Hill	Federally Qualified Health Centers	Focus Group and Key Informant Interview	Access, primary care, social determinants, behavioral health, mothers and infants, care coordination
CORHIO	Morgan Honea, Kate Horle	Regional Health Information Exchange	Key Informant Interview	Health data exchange infrastructure
InnovAge	Beverley Dahan	Long Term Services and Supports Provider	Key Informant Interview	Older adults/end of life, care transitions, primary care



Organization Name	Organizational Contact	Organization Type	Engagement Activity	Connection to any specific HTP priority populations and / or project topics, as applicable
Colorado Cross-Disability Coalition	Julie Reiskin, Dawn Howard, Kim Jackson	Consumer advocate	Key Informant Interview	Consumer advocacy, long-term services and supports, access, care transitions, high utilizers
Colorado Criminal Justice Reform Coalition	Terri Hurst	Consumer advocate	Key Informant Interview	High utilizers, care transitions, behavioral health, social supports, disconnected from system
Colorado Children's Campaign	Erin Miller	Consumer advocate	Key Informant Interview	Maternal child health, social supports
Denver Regional Council of Governments	Ron Papsdorf	Community organizations addressing social determinants of health	Key Informant Interview	Social determinants of health, long-term services and supports
Every Child Pediatrics	Jessica Dunbar	Primary Care Medical Provider	Key Informant Interview	Access, primary care, social determinants, behavioral health, mothers and infants, care coordination
Mile High & Foothills RETAC	Bill Clark	RETACs	Key Informant Interview	High Utilizers

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

Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
Partnership	In person	x1	All Health network/UCH-HRH	E-mail	Toured ATU, Colorado State University, OP clinics. Discussed potential level of need for HRH hospital, Reviewed referral process and services offered.



Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
Involvement	In person	x1	Several stakeholders	Public Announcement	Discuss ED MAT program, discussed HTP, made connections with community organizations and obtained key contacts from OBH.
Partnership	Phone	x1	Colorado Health & Human Services, Refugee Department and UCHHealth	E-mail	Understand refugee populations and potential opportunities for partnerships.
Partnership	Phone	x4	LPHAs in Denver Metro Areas, CHI, and denver metro hospitals.	E-mail	Discuss convening of HTP community stakeholders and mid-term report needs.
Partnership	Phone	x1	Colorado Health Literacy Coalition and UCHHealth	E-mail	Capture the health literacy rates by county and discussed partnership opportunities.
Involvement	CIVHC Board Room/In person	x1	Health Systems, Payers, CDPHE, CCMU	E-mail	SDOH white paper put together by CPA; RWJ work on community capacity was presented: <a href="https://www.rwjf.org/en/our-focus-areas.html">https://www.rwjf.org/en/our-focus-areas.html</a> . The group will no longer be meeting again.



Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
Partnership	UCH-A/In person	x4	MCPN/UCH-A	E-mail	Discussed current pregnant women TOC practices; gaps in care that exist in connecting patients post-partum with MCPN; project discussion on how to improve TOC. We discussed depression/anxiety screening tools for moms and follow up practices for those with positive scores.
Partnership	Phone	x1	RETAC-UCHealth	E-mail	Discussed HTP and role of RETAC in Foothills area. Valerie as the UCHealth representative sitting in the RETAC will present information on HTP to the remainder of the group. She felt the closest data or work on RETAC was on injury prevention.
Partnership	Phone	x1	RETAC-UCHealth	E-mail	Discussed HTP and understanding of RETAC. Shirley recommended presenting HTP and providing background to the state wide RETAC meeting that gathers all stakeholders-made introduction between Shirley and Matt Haynes, as the state HTP's representative. Also made introductions between CHI and Shirley for Denver Metro Hospitals.



Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
Partnership	In person	x1	Vivage and UCHealth	E-mail	Discussed Medicaid challenges and benefits related to transitions from hospitals to nursing homes. Discussed vulnerable populations and cross collaborations. RAE involvement in SNF care. Potential partnerships.

**The following community outreach was done by the Colorado Health Institute:**

Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
Consultation	Phone and in person	X10	CORHIO, Colorado Children's Campaign, CCH, Colorado Criminal Justice Reform Coalition, Denver Regional Council of Governments, Every Child Pediatrics, Innovage, Mile High and Foothills Retac	Email	Discussion around the health care challenges, gaps, and opportunities in the metro Denver community
Consultation	Location: offices of the Colorado Health Institute. Attendees participated either in-person or by webinar/phone.	X6	Colorado Access, Adams County Health Alliance, AllHealth Network, Aurora Health Alliance, Boulder County Health Improvement Collaborative, Broomfield FISH, Center for African American Health, Center	Email	Discussion around the health care challenges, gaps, and opportunities in the metro Denver community



Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
			for Health Progress, City and County of Denver, Clinica Family Health, Clinica Tepeyac, Colorado Coalition for the Homeless, Colorado Community Health Alliance, Denver Health and Hospital Authority, Denver Public Health, Douglas County Health Alliance, High Plains Community Health Center, Hunger Free Colorado, Jefferson Center for Mental Health, Jefferson County Public Health, Marillac Clinic, Mile High Health Alliance, Mountain Family Community Health Center, Peak Vista Community Health Center, Sheridan Health Services, Signal Behavioral		



Engagement Activity	Location and Manners for Participation	Frequency of Activity	Partners Included	How Activity Was Noticed	Key Deliverables
			Health, STRIDE Community Health Center, Sunrise Community Health Center, Tri-County Health Department		
Consultation	Online-Survey	Survey link was emailed once through partners' existing email distribution lists. Approximately 120 responses received as of April 11, 2019.	Mile High Regional Emergency Medical and Trauma Advisory Council, Jefferson County Health Alliance, Douglas County Health Alliance, Adams County Health Alliance, Aurora Health Alliance	Email	Insights around the health care challenges, gaps, and opportunities in the metro Denver community
Consultation	In person	X3	Adams County Health Alliance, Douglas County Health Alliance, and Jefferson County Health Alliance	Email	Discussion around the health care challenges, gaps, and opportunities in the metro Denver community



III.b. Please respond to the following questions to tell us about your experiences of executing your Action Plan, including the challenges you have faced and how, if at all, you have had to adjust in light of those challenges.

1. Please use the space below to describe:

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

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

UCHealth Highlands Hospital is not open yet. It will be located in Douglas County, and likely serve mostly Douglas County and Jefferson County residents. We worked with many groups in both counties. Still, due to the hospital not being open yet, talks were more about finding facts. Our group partners felt talking about working together and partnerships would be more fruitful once the hospital opens in 2019.

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

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

UCHealth Highlands Ranch is not yet open. It was a challenge to involve partners and not have hospital operations and local staff in place. The biggest challenge with carrying out the action plan activities was linked to the amount of time between Action Plans and Midpoint Reports. The state stressed using ongoing meetings as a way to have talks about gathering data and information needed for this report. But, since many community groups meet each quarter and hospitals were given 3 months to do the Midpoint report activities, this was a challenge.

The second challenge was related to the hospital not being opened. Community stakeholders felt that it would be better to wait until it opened so local leaders could come to meetings and be part of more. This would make things more productive and provide stronger collaborations. We have made several contacts with local groups and are ready to make introductions for when the hospital becomes fully staffed and in use.

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

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

As stated in the Action Plan, UCHealth Highlands Hospital is not yet open. We wrote an Action Plan to look at community groups that serve people in the hospital service area. We have been able to meet and develop new relationships with many partners.



We were part of community partnerships and ongoing community meetings. Also, we met alone with many stakeholders to ask about the Midpoint report questions.



## Environmental Scan Findings

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

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

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

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

The hospital defined the community based on its setting and the zip code of citizens that will use the hospital system. Also, hospital representatives met with many community stakeholders who gave input into how we defined the hospital community service area.

We do not have data for UCHHealth Highlands Ranch Hospital, but think that almost all of its users will be people from Douglas County and Jefferson County. So we have focused this report on both counties. In addition, the state gave us RAE data, which includes the layout of RAE region 3.

The Medical campus features include:

- 87 inpatient beds
- a Birth Center
- Level III NICU
- 18 intensive care units
- a Cancer Center
- 8 Operating Rooms

UCHHealth Highlands Ranch will be Level III Trauma Center. We do not have data about who will use the hospital, but we guess that the main users will be people of Douglas and Jefferson counties.

The Colorado Health Institute set up meetings for hospital partners that are part of the Metro Denver Partnership for Health's (MDPH) Public Health-Health Systems Collaboration Work Group. MDPH is a joint effort led by the 6 local public health agencies that serve the 7-county Denver Metro area, including:

Adams

Arapahoe



Boulder

Broomfield

Denver

Douglas

Jefferson

Also, there are many community groups that meet and review services, gaps and collaborations based on the aforementioned geographic definition. Furthermore, this area is a part of the larger Denver metro area and as such, we have also analyzed data and resources associated with this larger community, given many of local residents benefit from the larger Denver metro area resources and partnerships.

This environmental scan lined up the data collection and community partner outreach across the metro Denver region for these partner hospitals:

- Centura Health
- Children's Hospital Colorado
- Denver Health
- Health One
- National Jewish Hospital
- SCL Health
- UCHealth (UCHealth Broomfield Hospital
- UCHealth Highlands Ranch Hospital
- UCHealth University of Colorado Anschutz Medical Campus Hospital
- UCHealth Longs Peak Hospital

Colorado Department of Health Care Policy and Financing (HCPF) data are reported at the Regional Accountable Entity level:

RAE 3:

- Adams



- Arapahoe
- Douglas
- Elbert

RAE 5:

- Denver

RAE 6:

- Boulder
- Broomfield
- Clear Creek
- Gilpin
- Jefferson

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

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

We did many surveys and interviews with community groups. By being part of ongoing community meetings we could ask for needed facts. We also reviewed public records that contained points about the broad population of the area. We want to thank all of our partners for setting up groups of community stakeholders and sharing data with us.

We teamed up with the Regional Accountable Entity (RAE) and got data linked to the Medicaid population. The Health Policy and Finance (HCPF) Center also gave hospitals data on Medicaid members that used the hospital identified in this application. All data had any proof of who the members were taken off.

References:

[1] <http://www.countyhealthrankings.org/>

[2] American Community Survey (ACS), 2017

[3] [https://data-cdphe.opendata.arcgis.com/datasets/5878e60d6a714c5395fd934ec7f864e9\\_2](https://data-cdphe.opendata.arcgis.com/datasets/5878e60d6a714c5395fd934ec7f864e9_2)



- [4] <https://www.migrationpolicy.org/programs/data-hub/charts/us-immigrant-population-state-and-county>
- [5] <http://healthliteracymap.unc.edu/#>
- [6] Colorado Department of Public Health & Environment, 2011-2015
- [7] 2017 Douglas County Community Needs Assessment
- [8] 2018 Jefferson County Community Health Needs Assessment
- [9] <https://www.colorado.gov/pacific/hcpf/county-fact-sheets>
- [10] Health Care Policy and Finance, Hospital Transformation Program Data Source
- [11] <https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures.pdf>
- [12] <https://www.cdc.gov/ncbddd/disabilityandhealth/impacts/colorado.html>
- [13] <https://www.coloradohealthinstitute.org/research/suicides-colorado-reach-all-time-high>
- [14] Colorado Health Observation Regional Data Service (CHORDS), 2016-2017
- [15] <https://www.colorado.gov/pacific/cdphe/colorado-health-indicators>
- [16] <https://www.civhc.org/get-data/public-data/interactive-data/utilization/>
- [17] Accountable Care Collaborative, Potentially Avoidable Costs (PAC) Action Plan, Region 3, Colorado Access
- [18] <https://www.colorado.gov/pacific/cdphe/vision-data-tool>
- [19] 2018 Community Health Assessment, Tri-County Health Department (Adams, Arapahoe, Douglas), Colorado
- [20] <https://www.cohealthdata.dphe.state.co.us/chd/Resources/vs/2015>
- [21] [https://www.colorado.gov/pacific/sites/default/files/PF\\_Maternal-Mortality-fact-sheet.pdf](https://www.colorado.gov/pacific/sites/default/files/PF_Maternal-Mortality-fact-sheet.pdf)
- [22] <https://www.coloradohealthinstitute.org/research/colorado-health-access-survey>
- [23] <https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator>

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

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

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing.  
[www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)



We found many data gaps linked to people with Medicaid. Most public and community organization datasets are holistic and not set apart by payor source. We do not have any data for UCHealth Highlands Ranch Hospital, since it is not open. The state gave us data for the entire RAE region 3. But this is not a true picture of data use of the hospital.

There are still major gaps in data gathering because UCHealth Highlands Ranch Hospital is not yet open. We have gotten data about the quality of items (qualitative data) from our community partners. This is a second choice for data that can be counted (quantitative data).

Even with getting data from the Health Care Policy and Financing team and the RAE, neither group was able to give us with demographic data for Medicaid clients and Medicaid high utilizer clients such as:

- income
- employment status
- education
- health literacy levels

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

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

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

General Population:

According to the Robert Wood Johnson County Health Rankings 2019 Dataset,

Jefferson County

- 574,613 residents, comprising 10.25% of overall Colorado's population [1].
- 39,648 rural residents (6.9%)
- 450,122 (78.3%) Non-Hispanic Whites



- 6,293 (1.1%) African American
- 88,334 (15.4%) Latino/Hispanic
- 16,988 (3.0%) Asian
- 697 (0.1%) Native Hawaiian/Other Pacific Island Native

#### Age

- 114,923 (20.0%) below 18 years of age
- 367,178 (63.9%) between ages 18 and 64 years of age
- 92,512 (16.1%) were 65 years of age and older

#### Income and Employment Status

##### State of Colorado

- state of Colorado at 12.7% [4] at FPL
- (2.8%) unemployment rate
- median household income is \$69,100 [1]

##### Jefferson County

- 7.6% people living at or below the Federal Poverty Level
- unemployment rate is 2.6%
- median household income \$80,600

##### Douglas County

- unemployment rate (2.7%)
- median household income (\$136,284) [2]
- 15.0% living below 200% of the Federal Poverty Level (FPL)

Population: According to the Robert Wood Johnson County Health Rankings 2019 Dataset

Douglas County had:



- 320,940 residents, comprising 5.7% of overall Colorado's population [2]
- 39,648 rural residents or 6.9% [1]
- female at 50.1%
- males 49.9%
- 287,821 (89.7%) Non-Hispanic Whites
- 3,806 (1.2%) African American
- 26,740 (8.3%) Latino/Hispanic
- 14,158 (4.4%) Asian
- 197 (0.1%) Native Hawaiian/Other Pacific Island Native [2]
- 89,207 (27.8%) were below age 18 years of age
- 198,488 (61.8%) were between ages 18 and 64 years of age
- 33,245 (10.4%) were 65 years of age and older

#### Disability Status

##### Jefferson County

- West Jefferson County had lower rates of people with a disability (0.0% to 9.3%) when compared to East Jefferson County (9.4%-45.8%) [3].

#### Immigration Status

According to the Migration Policy Institute:

##### Jefferson County

- 10,300 foreign-born immigrants were living in Jefferson County [4]
- refugee settlement area in Denver Metro (80%)
- 116 refugees came in 2017

##### Douglas County

- 10,578 foreign-born immigrants [2]
- 0 refugees arrived in 2017

##### Weld County



- refugee settlement areas included Greeley at 13%

#### El Paso County

- refugee settlement areas in Colorado Springs at 7% [1,4]

#### Housing

#### Jefferson County

- homeownership rate is 71% or 161,274 residents

#### Douglas County

- homeownership rate is 79% or 90,431 residents

#### Education and Health Literacy Status

#### State of Colorado

- high school graduation rates in the state of Colorado is 79%

#### Jefferson County

- high school graduation rate is 83%
- 77% had some college education [1]
- The northeast Jefferson County health literacy rate was in the first and second lowest state quartiles made up of Quartile 1 and 2. While the rest of Jefferson County was within the 2 highest state quartiles made up of Quartile 3 and 4 [5].
- In 2019, there were 2% of people with an English proficiency deficiency [1].

#### Douglas County

- high school graduation rate is 12.9%
- 20.1% had some college education [6]
- According to the Health Literacy Data Map, there were pockets of residents in the second lowest state quartile, while all most all of Douglas County was within the two highest state quartiles [5].
- In 2019, there were 1% of residents with an English proficiency deficiency [1]



## Disability Status

### State of Colorado

- 12.7% rate of people with disability

### Douglas County

- 6.5% rate of people with disability [2]

## Unique characteristics that impact health residents:

### Douglas County

- Challenges and Community needs:
  - o Based on 2017 Douglas County Needs Assessment, affordable housing ranked as the highest need
    - Help paying rent
    - More choice for houses that can be afforded
    - Senior housing
    - Emergency housing
  - o A little over half of the people said that they do not have enough transportation options to get to:
    - medical visits
    - the grocery store
  - o integrated care and resource centers are the most important facility needed
  - o Child care and the cost of child care

### Jefferson County

- Strengths
  - o Access to parks (617 park spaces) and recreation areas (79,771 acres of open space)
  - o Healthy eating
  - o Breast feeding mothers (81% of mother breastfed their babies at 9 weeks old)



- Areas of opportunity
  - o 1 in 10 Jefferson County residents were food insecure
  - o Mental health and substance use treatment
    - 8.3% needed mental health care but did not receive it
    - 1.6% in the State or about 90,000 people who needed it, but did not get it in the same year [8].

#### Medicaid Population:

##### Jefferson County

- 96,720 Health First Colorado Members

##### Douglas County

- 27,770 Health First Colorado Members

#### Treatments at UCHealth Highlands Ranch Hospital

UCHealth Highlands Ranch Hospital is not yet open to the public. These facts reflect the Hospital Transformation Regional Accountable Entity (RAE) 3.

#### RAE 3's state report shows:

- 216,454 unique people with Medicaid assigned to RAE 3

##### Age

- 101,877 (47.1%) were below 18 years of age
- 107,261 (49.6%) were between 18 to 64 years of age
- 7,316 (3.4%) were 65 years of age and older

##### Gender

- 56.4% Female
- 43.6% Male



## Race &amp; Ethnicity

- 53,764 (24.8%) Non-Hispanic Whites
- 15,430 (7.1%) African American
- 29,934 (13.8%) Latino/Hispanic
- 349 (0.2%) Native Hawaiian/Other Pacific Island Native

## Disabilities

- 21,991 (10.2%) had permanent disabilities

## Immigration Status

- 10,492 (4.8%) Legal permanent residents
- 1,405 (0.6%) refugees
- 4,665 (20.2%) people without home

## Primary Language Spoken

- less than 5.7% spoke languages other than English

(The secondary language field had 36.6% missing responses. We may not have all the details.)

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

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

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

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing.  
[www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)



Individuals with significant health issues, co-occurring conditions, and high health care utilizers:

In the past year, RAE 3's state report named:

- 19,443 unique Medicaid high utilizer citizens who were assigned to RAE 3 and utilized a hospital in the past year [10].

#### Age

- 6,021 (31.0%) were below 18 years of age
- 13,382 (68.8%) were between 18 to 64 years old
- 40 (0.2%) were 65 years of age and older

#### Gender [10]

- 60.6% female
- 39.40% male (39.40%)

#### Race and Ethnicity

- 5,432 (27.9%) Non-Hispanic Whites
- 8,638 (44.4%) Multiple Races
- 1,582 (8.1%) African American
- 2,034 (10.5%) Latino/Hispanic
- 41 (0.2%) Native Hawaiian/Other Pacific Islander [10]

#### Disabilities

- 464 (2.4%) Medicaid enrollees had permanent disabilities

#### Immigration Status

- 67 (0.3%) Medicaid enrollees were legal permanent residents
- 461 (2.4%) were refugees [10]

#### Housing

- 1,308 (6.7%) people with no home covered by Medicaid [10]

#### Primary Language Spoken

- less than 2.4% of Medicaid enrollees who spoke languages other than English [10]



o But, the secondary language field had 17.7% missing responses. So, we may not have all of the facts [10].

Vulnerable Populations including related to maternal health, perinatal, and including outcomes of birth and end of life care:

Compared to women covered by private insurance, Medicaid covered pregnant women tend to:

- be between ages 20 to 34 years
- be adolescents
- be single mothers
- have fewer years of education
- be obese
- have a diagnosis of:
  - o diabetes
  - o mental health
  - o substance use disorder
- be more likely to use the emergency department

Individuals with behavioral health disorders:

- single largest payer in the U.S. for behavioral health disorders including:
  - o mental health
  - o substance use disorders [10]
- most common mental health disorder is major depressive disorder
- females are more likely to have a mental health disorder than male enrollees
- African Americans and Latino/Hispanics with Medicaid are more likely to have a mental health disorder, compared to Whites.
- Members with disabilities are more likely to also have a mental health disorder or substance use disorder.
- About 1 in 4 Medicaid members diagnosed with a mental health disorder also have some other issues such as substance use disorder.



- More likely to be divorced or separated compared to people with mental health disorders that have private insurance.
- Less likely to work full time compared to a person with behavioral health disorders that have private insurance.
- are mostly young, between ages 18 and 55 years of age
- Chronic physical health and behavioral health issues in this group looks like the broad population.
- o But the costs linked with a Medicaid member having another physical and behavioral health problem is 3 times more than a Medicaid member with only a physical chronic disease.

Other populations of need:

People with disabilities

- have complex health care and social needs
- In Colorado, there were 17% of people who lived with some disability
- o compared to the U.S. with 23% [12]

As stated by Medicaid claims, a large part of Medicaid health care costs came from people with disabilities.

About 32.7% of adults in Colorado with disabilities were more likely to be inactive compared to 16.3% of those without disabilities [12].

Adults in Colorado with disabilities were also more likely to:

- have high blood pressure
- smoke
- be obese, compared with those without disabilities [12]

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

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

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

Serious Behavioral Health Disorders:

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) is a government-owned business within the Department of Health Care Policy and Financing.  
[www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)



Death rate due to suicide

Douglas County

- 13.73 per 100,000

Jefferson County

- 17.41 per 100,000

State of Colorado

- 19.5 per 100,000 [13]

Denver Metro Area's percent of high school students who seriously thought about attempting suicide during the past 12 months is 16.0%.

- The rate in Douglas County is 15.9%
- The rate in Jefferson is 15.9% [6]

UCHealth Highlands Ranch Hospital has not opened its doors as of this time. So there is no data about the use of the hospital to know how diseases affect use. The state provided only regional accountable entity data. We can suppose things from this dataset, but several essential disease characteristics, including serious mental health disorders, were missing from this dataset as well.

Substance use Disorders including alcohol, tobacco, and opiate abuse:

The percent of adults aged 18 years and older who said they had been binge drinking in the past 30 days was:

- 19.4% for the Denver Metro
- 15.6% for Douglas County
- 17.9% Jefferson County [14]

Alcohol abuse and dependence was a common cause of hospital admissions for many Medicaid members with chronic conditions. The region 3 Regional Accountable Entity common inpatient diagnostic related group expense is alcohol abuse and dependence diagnosis. No other substance use disorder codes were noted as a common diagnosis in the state Medicaid dataset [9].

The Colorado Health Observation Regional Data Service (CHORDS) shows that adult tobacco use:



- is 8.6% in Douglas County
- is 16.1% in Denver Metro area
- is 16.4% in Jefferson County [14]

Opioid Use Disorder is:

- 0.7% in the Denver Metro Area
- 0.7% in Jefferson County
- 0.3% in Douglas County

Adult depression is:

- 11.1% in the Denver Metro Area
- 12.1% in Douglas County
- 14.4% in Jefferson County [14]

Other significant physical chronic conditions:

The leading causes of death in Douglas County are:

- cancer (malignant neoplasms) (114.7 per 100,000 population)
- heart disease (89.4 per 100,000 population)
- unintentional injuries (34.9 per 100,000 population)
- Alzheimer's disease (35.0 per 100,000 population)
- stroke (cerebrovascular diseases) (29.8 per 100,000 population) [15]

The leading causes of death in Jefferson County are:

- cancer (malignant neoplasms) (133.7 per 100,000 population)
- heart disease (132.5 per 100,000 population)
- chronic lower respiratory disease (49.9 per 100,000 population)
- unintentional injuries (49.2 per 100,000 population)
- Alzheimer's disease (35.7 per 100,000 population) [15]

High blood pressure was the most commonly diagnosed chronic disease in the state of Colorado (12%) [16].



In general, adult high blood pressure rates are:

- 15.5% in Denver Metro Area
- 16.3% in Douglas County
- 16.2% in Jefferson County [14]

Adult diabetes rates are:

- 6.2% in Douglas County
- 7.3% in the Denver Metro Area
- 7.0% in Jefferson County

Rates for diabetes in the Medicaid population:

- 7.3% for Douglas County
- 9.8% for Jefferson County

Compared to the rest of the state, Jefferson County had higher levels of chronic respiratory diseases such as:

- asthma
- chronic obstructive pulmonary disease [16]

Compared the rest of the state, Douglas County had lower levels of chronic respiratory diseases such as:

- asthma
- chronic obstructive pulmonary disease [16]

As stated by the Department of Public Health and Environment, there were many rates that were affected by someone's age in Douglas and Jefferson counties that added to other major physical chronic conditions.

Looking at only certain age groups together (the age-adjusted rate) for being in the hospital for congestive heart failure in:

- Denver Metro Area was 701 out of 100,000 people
- Douglas was 531 out of 100,000 people
- Jefferson was 597 out of 100,000 people [6]



Looking at only certain age groups together (the age-adjusted rate) for being in the hospital for heart disease in:

- Douglas was 2,034 out of 100,000 people
- Jefferson County was 1,977 out of 100,000 people
- Denver Metro Area was 2,266 out of 100,000 people [6]

Looking at only certain age groups together (the age-adjusted rate) for being in the hospital for stroke in:

- Douglas County was 215 out of 100,000 people
- Jefferson County was 242 out of 100,000 people
- Denver Metro Area was 248 out of 100,000 people [6]

Looking at only certain age groups together (the age-adjusted rate) for being in the hospital for a heart attack in:

- Douglas County was 113 out of 100,000 people
- Jefferson County was 140 out of 100,000 people
- Denver Metro Area was 151 out of 100,000 people [6]

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

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

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

Top chronic conditions accounting for most utilization (include both physical and behavioral health chronic diseases):

Douglas County

- 63.0% of people have 1 or more long-term (chronic) diseases
- 3 main cause of life lost before age 75 include:



- o accidents or unintentional injuries
- o suicide
- o cancer [8, 19]

#### Jefferson County

- 66.4% of people have with 1 or more long-term (chronic) diseases
- 3 main cause of life lost before age 75 include:
  - o accidents or unintentional injuries
  - o suicide
  - o cancer [8, 19]

#### State of Colorado

- 62.7% of people have with 1 or more long-term (chronic) diseases [18]
- According to the state, those with high blood pressure and bone disease were the cause of high use of hospital days and overall costs.
- Those with chronic kidney disease appeared to also have congestive heart failure.
- High blood pressure was seen often with alcohol abuse and dependence [10].

#### Quality of Life markers [1]

##### Douglas County

- 2.5 days of poor physical health
- 2.9 mental health days

##### Jefferson County

- 2.8 days of poor physical health
- 3.2 mental health days

##### State of Colorado

- 3.4 days of poor physical health
- 3.6 mental health days



According to the state record set showing people that use services more often than others (high utilizer dataset) for RAE 3, there were 17,834 emergency department (ED) high utilizers or more than or equal to 4 ED visits each year. This accounted for 80,675 ED visits over a period of 12 months.

The average number of ED visits by each Medicaid high utilizer for RAE 3 was 4.5 ED visits each year. In the state of Colorado, there were 6.3 ED visits each year by those that use services more than others [10].

RAE 3 shared its Potentially Avoidable Costs (PAC) with hospitals to help us further understand which chronic diseases were driving these costs.

23% of all Colorado Access PACs were related to chronic diseases at the cost of \$270,481,227.

The top 3 PAC episodes of care were for:

- asthma where:
  - o 5,262 Medicaid members accounted for a total split cost of \$3,958,011 and \$2,346,377 in ED potentially avoidable costs.
- diabetes where:
  - o 3,236 Medicaid members accounted for a split cost totaled \$2,826,319 and \$2,818,025 in inpatient potentially avoidable costs.
- chronic obstructive pulmonary disease:
  - o where 243 Medicaid members accounted for \$1,113,228 in inpatient costs that may have been avoided [17]

We do not have hospital data yet to be able to comment on the true reasons of why people came to the hospital.

Physical health conditions that commonly co-occur with mental health diagnoses:

Douglas County

- rate of depression is 17.7%
- rate of anxiety is 13.6%

Jefferson count

- rate of depression is 18.8%
- rate of anxiety is 16.5%

State of Colorado



- rate of depression is 18.4%
- rate of anxiety is 16.4% [18]

According to the state dataset, members who got care from community mental health centers and also used a hospital most commonly stayed in a hospital for:

- pulmonary edema and respiratory failure
- septicemia, and disseminated infections
- seizure [10]

Though it did not happen often, being admitted to the hospital for infections or a disease from parasites, is costly. But when people with behavioral health issues were admitted for these reasons, those days in the hospital cost more than for others patients.

Vulnerable Populations including related to maternal health, perinatal, and including outcomes of birth:

Douglas County

- 3,417 live births

Jefferson County

- 5,869 live births [20]

According to RAE 5

- 57% of pregnant women with Medicaid received adequate prenatal care
- 31.2% of pregnant women with Medicaid received appropriate postpartum care

In Colorado

- 53.4% of pregnant women with Medicaid received adequate prenatal care
- 30.6% of pregnant women with Medicaid received appropriate postpartum care

According to RAE 3:

- Vaginal delivery rates were the highest in potential savings

We were not able to look at the episodes linked to potentially avoidable costs. But it seems that high rates of Cesarean sections might be the leading cause of these in-patient costs.

- Colorado ranked 29th in the U.S. for death rates of a woman that is pregnant or has just given birth.



- o Over 60% of these deaths happened after giving birth.
- o Behavioral health had been identified as the leading cause of maternal death [21].

Other populations of need and end of life care:

- According to the state dataset, RAE 3 Medicaid members getting hospice services most often were in the hospital for:
  - o blood poisoning (septicemia) and disseminated infections
  - o alcoholic liver disease
  - o fluid in the lungs (pulmonary edema) and respiratory failure [6]

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

(a) Service availability, access, and perceived gaps generally as well as related to HTP priority populations and project topics, including related to:

- i. Primary care;
- ii. Specialty care;
- iii. Long term care;
- iv. Complex care management;
- v. Care coordination via primary care or other providers;
- vi. Maternal health, perinatal, and improved birth outcomes;
- vii. End of life care;
- viii. Behavioral health;
- ix. Other outpatient services;
- x. Population screenings, outreach, and other population health supports and services; and
- xi. Any other areas of significant capacity gaps.

(b) Qualified staff recruitment and retention concerns, particularly related to the services listed in (a).

(c) Resources and gaps related to care transitions among specific populations or across major service delivery systems, including:

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



(d) Social supports related to social factors impacting health outcomes specific to HTP priority populations:

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

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

- i. Housing;
- ii. Homelessness;
- iii. Legal, medical-legal, financial;
- iv. Nutrition;
- v. Employment and job training; and
- vi. Transportation.

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

Primary Care:

- The resident to primary care ratio is highest in Denver County at 2,340 residents to every 1 doctor.
- The resident to primary care ratio is lowest in Broomfield County at 980 residents to every 1 doctor.
- The resident to primary care provider ratio in Colorado is 1 primary care provider for every 1,230 residents.
- It is not clear what access for Medicaid members is like, since not all practices accept Medicaid members.

The most common primary care practices that will likely serve Medicaid residents using UCHHealth Highlands Ranch include:

- Stride
- UCHHealth
- Clinica

Partners named gaps in primary care that can serve as medical homes for high-need patients, along with disease management services. Access to primary care was thought of as uneven across the metro area. Care is simpler to find in the cities and less in the outlying areas.

Specialty Care:

The metro Denver area has limited access to specialty care providers for all people, according to some community partners. However, Medicaid enrollees are especially underserved given the high demand for services. Unique specialty needs include:



- orthopedics
- neurology
- gastroenterology
- dermatology
- oncology
- any surgical care

Geriatric care specialists were also identified as limited in the region.

E-consultations or office visits that take place using the computer, were mentioned as a solution for opening access to specialty care. Partners felt there was a need for Medicaid to cover e-consultations to increase the incentives for providers to offer this service.

#### Long Term Care:

Assisted living was described as “available” for Medicaid enrollees. But partners did talk about the challenges in timing for getting patients approved for long term care through Medicaid. There is a 3 to 5 day stay minimum. Also, not all people that have both Medicare-Medicaid are screened for or referred to the long-term services and supports (including PACE) for which they may be eligible.

Partners also talked about a need for services that can house more complex people. This is for acute care needs such as rehab for a broken hip. But it also means services for chronic conditions such as:

- diabetes
- a person with limited social supports including:
  - o housing
  - o healthy food
  - o transportation

Long-term care services especially home health, was termed by some partners as limited. This includes skilled care. There are also few choices for patients.

#### Complex Care Management and Care Coordination via Primary Care or Other Providers:

All Medicaid members can get care coordination. This is to include basic and complex care coordination services through the regional accountable entities (RAEs). The RAE may either:

- give direct care coordination services



- subcontract care coordination services to centralized teams or primary care medical homes

Most community partners identified gaps in the current complex care management and care coordination services. One partner shared that “everyone is doing care coordination, but very little of it is coordinated.” One partner shared that “poor communication with and among health care organizations” was one of the greatest challenges in the metro region.

Maternal Health, perinatal and improved outcomes:

Pregnant patients do use the emergency department, often during the first trimester. There are many OB providers in the Denver Metro area.

Home visitation programs provide a service that could:

- promote maternal health
- improve perinatal health
- improve birth outcomes

Many public health agencies and community partners provide these services, but partners felt the supply was limited. The local public health agencies also connect women with Women Infants and Children (WIC) services. Still, connecting pregnant women or new mothers to these services from the hospital can be hard.

Partners stated that more emergency training for maternal health care is needed for emergency department providers.

End of Life Care:

Partners focused on the role of advance care directives as a way to get end of life care. Just over 1 of 3 residents (35.9%) in the metro area have an advance care directive. Douglas County residents are most likely to have an advance care directive (48.3%) and Denver County residents least likely (28.4%) [17].

Partners shared that hospitals were “doing a good job” of asking patients about having an advance care directive. But they suggested that other providers, including primary care doctors need to stress these messages. Just 40% of people in the metro area report ever having had a serious talk about their advance directive with a health care provider.

Behavioral Health:

Most partners shared that behavioral health services are limited. Still one partner shared that even when more open slots added, they are quickly filled. This suggests there may never be enough services to meet needs.

In averaging the number of people to mental health providers, the Denver Metro area, there were 447 residents per provider.



- Douglas County has the highest number of mental health providers per resident (1000:1).
- Boulder County has the lowest number of mental health providers per resident (150:1).
- In the state of Colorado for every mental health provider there are 300 residents [1].

Still, it is not clear how many behavioral health providers take new patients with Medicaid. More and more practices in the Denver Metro area can provide behavioral and physical health services. This is improving access to behavioral health services.

Many partners talked about workforce gaps for medication-assisted treatment (MAT). According to the SAMSHA, there are over 100 medical providers able to prescribe buprenorphine in the Denver Metro area. This is a medicine used to treat opioid use disorder [19].

Still, it is not clear how many of those providers are actively prescribing this medicine and taking new Medicaid members. Such as, one partner talked about a need for providers who can work with a patient throughout this process, starting with withdrawal. There are not established mentor systems offered right now in the region that connect comfortable, experienced providers with ones new to the process.

Residential and outpatient substance use treatment services were identified as especially limited. This is even more so for:

- people with both behavioral health (mental health and substance use) and physical health concerns
- people who also have developmental or intellectual disabilities

Most partners felt positive about the availability and capacity of the peer workforce.

#### Other Outpatient Services:

Partners did not specifically name other outpatient services needed that have not already been addressed in other areas.

#### Population screenings, outreach, and other population health supports and services:

The UCHHealth Medical Group takes part in providing population health services and supports. The RAEs also have population health plans that are state approved. The RAE is charged with for giving care coordination to all of its Medicaid members. Gaps include connecting these services and data across many groups. The goal is to not copy services and offer and to make sure there is no break in the care for patients.

#### Opportunities for partnerships:

#### HTP Priority Area: High Utilizers & Vulnerable Populations



Data shows that helping those who use services more than others (over-utilizers) use services less takes many methods to make it happen. This includes:

- looking into the social determinants of health, such as food insecurity
- improving access to primary care and care coordination
- looking into behavioral health needs

We have found chances for partnership with key partners looking into 2 of the 3 areas. The RAE has a team of care coordinators that have the job of providing Medicaid member care coordination services. Partnering with the RAE, major primary care medical homes or Federally Qualified Health Centers will help set up talks between the hospital and community services as Medicaid members are discharged.

#### HTP Priority Area: Behavioral Health

Both Mental Health Partners and the RAE have interests in joining forces to improve care for patients with behavioral health. There is a need to help join patients with the ambulatory care setting. Several community-wide opioid advocacy groups have talked about interventions and resources in this area.

#### HTP Priority Area: Social Determinants of Health

Many agencies speak to the social determinants of health, but their resources are limited. There is a wish to know how large the issue of the social determinants of health in a community is and share referral data across different settings.

#### HTP Priority Area: Maternal Health

Both Obstetricians and the RAE have interests in partnering to make maternal health better. Most, if not all, local public health agencies also have programs that aim for the care of women after giving birth.

Specific resources and gaps are described below.

General resources, gaps, and concerns:

Having social service providers in health system settings was identified as a best practice that could be made larger. People may be “captive audiences” in a hospital emergency department or inpatient bed. While providers may not have all the needed forms to fill out for programs like SNAP or WIC, they can make vital steps in connecting people with services such as:

- meeting someone face-to-face to talk about a program
- getting the right contact information
- starting the process



Also, some people may be worried about having to visit a county office to sign up. One partner felt that hospital social workers are giving patients lists of services, but not necessarily making connections. Placing these providers in hospital settings is a chance to make sure the patient feels comfortable with the next step of care. Also, helping someone to the next step may help them to not have to come back to the hospital or emergency room.

Population-specific resources, gaps, and concerns:

1. Maternal care transitions are vital for parent and child health. Hospitals were named as trusted providers with unique connections and time with parents during the delivery stay. Hospitals can talk straight to new parents during a very sensitive time such as the delivery and hospital stay. This is a chance to:

- a. increase awareness of depression in new mothers
- b. screen for:
  - i. depression in new mothers
  - ii. substance use
  - iii. other social services (such as WIC or SNAP)
- c. behavioral health concerns
- d. promote and support new parents with breastfeeding
- e. talk about:
  - i. immunizations
  - ii. oral health
  - iii. healthy eating strategies for new parents

2. People that do not have a home were often named as being hard to set up transitions for. This is mainly due to the basic need for housing. Some cases to use may include the Jefferson County Regional Homeless Navigator model. This helps connections across many cares and social needs in the county's cities. To help people without a home when they are admitted or discharged from a hospital, the Colorado Coalition for the Homeless has also developed partnerships with area hospitals including:

- o Denver Health
- o SCL
- o St. Joseph Hospital
- o UCHHealth Anschutz



3.Setting up a way for doctors to talk to each other before a patient is moved from hospital to long term care or is admitted from long term care, was named as very important to community partners.

These talks are a key way to name which group will manage care for the patient. Other types of care transitions may also benefit from these doctor-to-doctor talks to share details about the patient.

#### Challenges/Concerns:

Many partners felt that a transition is only a success if services exist when a person is ready to use them. Many partners shared that it was a challenge to find a patient that they did not meet while they were in the hospital. They felt that the chance that the patient would get the care and supports needed were low if no meeting took place. The need for going to the emergency room or having to come back to the hospital was higher when they could not connect with the patient early on.

#### Housing/Homelessness:

Most all community partners listed housing as one of the major gaps in social supports for HTP priority populations. This ranged from safe housing settings, mostly for older adults or the frail elderly as well as children with special health care needs. Permanent supportive housing is needed. This includes “wrap-around” services to address people’s needs for:

- medical care
- behavioral health care
- social issues

These supports are also lacking in supply for people with behavioral health and physical health concerns. Some partners mentioned the sober living homes open for use in the metro area and cited a need to grow these services.

The total lack of housing that can be afforded in the metro area, including limited apartment capacity, was named as a dire need for low-income Medicaid enrollees. Partners see people often moving around, which impacts whether and how they access care. This involuntary displacement may also negatively impact behavioral health. People with low-incomes facing life-long and complex health conditions may have less assets to use for other basics like food and housing as they struggle to cover health care costs.

Partners also talked about the impact that not having enough affordable has on care delivery and workforce. This is very hard for lower-paid employees like nursing aids or home health workers.

Those dealing with lack of housing face a tough time when moving from the hospital to back to the community. There are also fears about public health diseases outbreaks such as tuberculosis, hepatitis, and so on.



Medical homeless respite is a funded resource by Medicaid in other states. It has strong proof that it lowers readmissions and inpatient length of stay. In Colorado, this is not a service that is paid for and one that is hard to find in the community.

#### Legal, Medical/Legal, and Financial Services:

The metro area has had many pilot programs for services related to help with:

- legal needs
- medical-legal needs
- financial services

These have been valuable for streamlining care and making health better. These may be especially relevant for people with serious behavioral health conditions or people with dementia. They often don't have a chosen power of attorney or caregivers who can or are willing to do this when care decisions are needed.

#### Nutrition:

There are some community resources and services available to meet patients' nutritional needs. This may include groups like Hunger Free Colorado that can enroll patients in SNAP or WIC. Others also mentioned home-delivered meals that may be offered through non-profit groups such as Project Angel Heart or Meals-on-Wheels.

These services are in high demand. They also have limited on what they can do to help. This is true most often for Meals-on-Wheels. Having a way to get healthy, nutritious food is a known need among people dealing with having nowhere to live.

#### Transportation:

One community partner described the Non-Emergency Medical Transportation (NEMT) program as a challenge to use. Such as, a patient may miss an outpatient visit with a specialist due to a late or missed NEMT pick-up. They are then barred from getting future visits set up and then have to visit an ER. This may be due to either due to worsening conditions or an idea that the only way to get specialty care is through an ER.

Like concerns were cited for people who count on public transportation. It is hard to get to care visits on time. Many partners talked about how few people with low-incomes own cars and the challenges this makes for getting places. Partners talked about the need to support the Regional Transportation District's fare reductions for low-income households.

Pilot programs that connect people to ride-sharing programs such as Uber or Lyft were mentioned by a few partners. This may be another promising plan, especially for less-mobile groups of people.

#### Job/Training:



Gaps in the behavioral health workforce to staff residential or treatment programs were mostly identified as:

- licensed clinical social workers
- psychiatrists
- nurses

There are challenges to hire and keep people in the metro Denver area. This is largely from competition from non-profit groups that can offer higher salaries. Some people mentioned that home health employees caring for people with Medicaid might also be enrolled in Medicaid themselves.



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

Facility Type	Facility Name	Facility Address	Services Offered
Outpatient Clinic	UCHealth TomoTherapy Cancer Care Clinic - Lone Tree	10463 Park Meadows Drive Lone Tree, CO 80124	Cancer Treatment,Radiology
Outpatient Clinic	UCHealth Sue Anschutz-Rodgers Eye Center - Lone Tree	9552 E. Park Meadows Drive Lone Tree, CO 80124	Eye Care
Outpatient Clinic	UCHealth Primary Care Clinic - Lone Tree	9540 Park Meadows Drive Lone Tree, CO 80124	Diabetes,Endocrinology,Family Medicine,Flu Shot,Pediatrics,Primary Care,Seniorsâ€™ Health,Womenâ€™s Health
Outpatient Clinic	UCHealth Physical Therapy and Rehabilitation Clinic - Lone Tree	9548 Park Meadows Drive Lone Tree, CO 80124	Occupational Therapy,Physical Therapy
Surgical Clinic	UCHealth Lone Tree Surgery Center	9218 Kimmer Drive Lone Tree, CO 80124	Plastic and Reconstructive Surgery,Surgery
Outpatient Clinic	UCHealth Lone Tree Medical Center	9548 Park Meadows Drive Lone Tree, CO 80124	Audiology,Cardiology,Digestive Health,Endocrinology,Family Medicine,Gastroenterology,Neurology,Occupational Therapy,Orthopedics,Physical Therapy,Pregnancy Care,Primary Care,Surgery,Transplant,Urology,Womenâ€™s Health
Outpatient Clinic	UCHealth Hearing and Balance Clinic - Lone Tree	9548 Park Meadows Drive Lone Tree, CO 80124	Audiology,Ear Nose and Throat
Radiology	UCHealth Radiology - Lone Tree	9548 Park Meadows Drive Lone Tree, CO 80124	Imaging,Radiology
Outpatient Clinic	UCHealth Breast Center - Lone Tree	9544 Park Meadows Drive Lone	Imaging,Mammography,Plastic and Reconstructive Surgery,Radiology,Surgery,Womenâ€™s Health



Facility Type	Facility Name	Facility Address	Services Offered
		Tree, CO 80124	
Emergency Department	UCHealth Emergency Room - Parker (Freestanding)	16990 Village Center Drive East Parker, CO 80134	Emergency Room
Outpatient Clinic	UCHealth Facial Plastic Surgery Clinic - Lone Tree	9544 Park Meadows Drive Lone Tree, CO 80124	Plastic and Reconstructive Surgery
Hospital	UCHealth Highlands Ranch Hospital	1500 Park Central Drive Highlands Ranch, CO 80129	Hospital
Outpatient Clinic	UCHealth Castle Rock Medical Center	4404 Barranca Lane Castle Rock, CO 80104	Occupational Therapy
Outpatient Clinic	UCHealth Primary Care Clinic - Castle Rock	4404 Barranca Lane Castle Rock, CO 80104	Family Medicine,Flu Shot,Primary Care
Urgent Care	UCHealth Urgent Care - Castle Rock	4404 Barranca Lane Castle Rock, CO 80104	Urgent Care
Outpatient Clinic	UCHealth Physical Therapy and Rehabilitation Clinic - Castle Rock	4404 Barranca Lane Castle Rock, CO 80104	Physical Therapy,Rehabilitation,Sports Medicine
Outpatient Clinic	UCHealth Family Medicine Clinic - Littleton	206 W. County Line Road Highlands Ranch, CO 80129	Family Medicine,Flu Shot,Primary Care
Outpatient Clinic	UCHealth Maternal Fetal Medicine Clinic - Lone Tree	9548 Park Meadows Drive Lone Tree, CO 80124	Genetics,Neonatal,Pregnancy Care



Facility Type	Facility Name	Facility Address	Services Offered
Outpatient Clinic	UCHealth Center for Midwifery - Lone Tree	9548 Park Meadows Drive Lone Tree, CO 80124	Pregnancy Care, Reproductive Health, Women's Health
Outpatient Clinic	UCHealth Urology Clinic - Lone Tree	9548 Park Meadows Drive Lone Tree, CO 80124	Urology
Outpatient Clinic	UCHealth Occupational Medicine Clinic - Castle Rock	4404 Barranca Lane Castle Rock, CO 80108	Occupational Medicine
Emergency Department	UCHealth Emergency Room - Highlands Ranch (Freestanding)	9475 S. University Boulevard Highlands Ranch, CO 80126	Emergency Room
Outpatient Clinic	UCHealth Family Medicine Clinic - Hilltop	19964 Hilltop Road Parker, CO 80134	Family Medicine, Flu Shot, Primary Care
Outpatient Clinic	UCHealth Sterling Ranch Medical Center	8155 Piney River Avenue Littleton, CO 80125	
Outpatient Clinic	UCHealth Primary Care Clinic - Sterling Ranch	8155 Piney River Avenue Littleton, CO 80125	Family Medicine, Flu Shot, Primary Care
Urgent Care	UCHealth Urgent Care - Sterling Ranch	8155 Piney River Avenue Littleton, CO 80125	Urgent Care
Outpatient Clinic	UCHealth Physical Therapy and Rehabilitation Clinic - Sterling Ranch	8155 Piney River Avenue Littleton, CO 80125	Physical Therapy, Rehabilitation
Outpatient Clinic	UCHealth Occupational Medicine Clinic - Sterling Ranch	8155 Piney River Avenue Littleton, CO 80125	Occupational Medicine
Outpatient Clinic	UCHealth Primary Care Clinic - Yosemite	9695 S. Yosemite Street Lone	Primary Care



Facility Type	Facility Name	Facility Address	Services Offered
		Tree, CO 80124	
Outpatient Clinic	UCHealth Dermatology Clinic - Lone Tree	9548 Park Meadows Drive Lone Tree, CO 80124	Dermatology
Outpatient Clinic	UCHealth Gastroenterology Clinic - Lone Tree	9548 Park Meadows Drive Lone Tree, CO 80124	Digestive Health,Gastroenterology
Outpatient Clinic	UCHealth Ear, Nose and Throat Clinic - Lone Tree	9548 Park Meadows Drive Lone Tree, CO 80124	Audiology,Ear Nose and Throat
Outpatient Clinic	UCHealth Family Medicine Clinic - Westminster	7403 Church Ranch Boulevard, Suite 107 Westminster, CO 80021	Family Medicine,Flu Shot,Pediatrics,Primary Care
Hospital	UCHealth Broomfield Hospital	11820 Destination Drive Broomfield, CO 80021	Hospital
Free-standing Emergency Room	UCHealth Emergency Room - Littleton (Freestanding)	13351 W. Bowles Avenue Littleton, CO 80127	Emergency Room
Free-standing Emergency Room	UCHealth Emergency Room - Arvada (Freestanding)	9505 Ralston Road Arvada, CO 80002	Emergency Room
Emergency Department	UCHealth Emergency Room - Arvada West	15240 W. 64th Avenue Arvada, CO 80007	Emergency Room
Emergency Department	UCHealth Emergency Care - Broomfield Hospital (Hospital-based)	11820 Destination Drive Broomfield, CO 80021	Emergency Room
Urgent Care	UCHealth Urgent Care - Arvada West	15240 W. 64th Avenue	Urgent Care



Facility Type	Facility Name	Facility Address	Services Offered
		Arvada, CO 80007	
Outpatient Clinic	UCHealth Primary Care - Arvada West	15240 W. 64th Avenue Arvada, CO 80007	Family Medicine, Primary Care
Outpatient Clinic	UCHealth Greeley Medical Center	1900 16th Street Greeley, CO 80631	Allergy, Cardiology, Diabetes, Imaging, Primary Care, Pulmonology, Rehabilitation, Surgery
Laboratory	UCHealth Laboratory - Broomfield Hospital	11820 Destination Drive Broomfield, CO 80021	Laboratory

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

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

UCHealth uses EPIC© as its electronic health record platform across all hospitals and ambulatory clinics. Patient's records are available through Care-Everywhere.

UCHealth is also part of the CORHIO (Colorado Regional Health Information Organization) by sending in electronic health record information. CORHIO has been collecting and storing data since 2009. There are more than 16,000 health information exchange (HIE) users and nearly 5.6 million unique patients in the HIE. The RAE and select primary care practices also get data from CORHIO.

UCHealth hospitals can share data with CORHIO, RAE, and primary care providers. However, CORHIO data cannot be seen in EPIC©. To see data clinicians must log in to the CORHIO website: Once on the site they can see details related to:

- admissions
- discharges
- transfers
- lab results

Current gaps include not being able to:



- see the plan of care that is in use at the current time
- quickly find high utilizers without reviewing all visits in the electronic health record, and
- find if patients followed up on recommended social services or health care agency referrals if it was with an external health system.
- see primary care notes that are not in Care-Everywhere
- share data on people with substance use disorder secondary to 42 CFR regulations

Finally, the RAE has access to the patient's risk scores and complex care plans for COUP patients (Client Overutilization Program). Still, at this time there is no way to share such care plans and risk stratification scores. Also, it is a challenge to find Medicaid members who get home-based community services (HCBS) as they use the hospital. This is because the care management staff does not have access to such information in a timely fashion.

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

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

There were no other major topics shown other than the ones talked about in this form.

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

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

The Midpoint report shows what the needs are in the community right now. We focused on finding the resources that are in place already. Our next step is to talk about what we found with our partners. We need to find how we can work together in areas that are already in place between hospitals and community based services.

We will be talking about the HTP initiatives focus with our community partners in this next phase of the HTP pre-waiver period.

From the needs assessment and scan of the area, we found that the main items groups ask for as their most important needs are in behavioral health (including mental health and substance abuse) and care transitions.

Resources that will help the Medicaid population to have the structure needed for transitions of care are available. These are found through:

- o the RAE
- o local public health agencies
- o other community agencies



During this process, we found that we have partnership projects now underway with many community organizations. We also found that our hospital care management team works with many of the resources in the community already.

As we set up any screening or transitions programs for this patient group, we will make sure we can find resources in the area as well.

V.a.

We will keep on working with groups so we can blend activities and make sure outcomes for people are helped. We will see these results in the data collected for the HTP. The community health needs process let us to find the areas we needed to focus on first. These will likely change and grow as we work closely with the state, RAE, and community partners over the next 5 years.

The community health needs engagement process showed the areas that people felt were the most important to work on first. We will choose groups of people to focus on and make sure our plans line up with the HTP priorities and areas to be measured. Over the next few months as we pick projects for the Hospital Transformation Program, we will think over:

- stakeholder input
- feasibility
- sustainability
- cost

Throughout the HTP pre-waiver phase, we have shared our reports for the state with stakeholders and asked for feedback from our partners. We know this record will be made public by the Health Care Policy and Financing Department. We welcome any feedback that you may feel will add value to the final HTP report. The UCHHealth contact names and email address are found on the first page of this form.



## Planned Future Engagement Activities

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

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

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

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

We will continue to partner with critical organizations where the alignment of activities will lead to improved outcomes as demonstrated by the metric performance of the Hospital Transformation Program. The community health needs engagement process allowed us to determine key community priorities. These will likely evolve, and we will work closely with the state, RAE, and community partners over the next five years.

While the community health needs engagement process demonstrated key areas prioritized by the community, we will select "target populations" and "initiatives" that also align with the HTP priority areas and metrics. In the next few months, we will take into account stakeholder input, feasibility, sustainability and cost in selecting projects for the Hospital Transformation Program.

Throughout the HTP pre-waiver phase, we have shared our state deliverables with stakeholders and asked for feedback from our community partners. We understand this application will be made public by the Health Care Policy and Financing Department. We welcome any feedback that you may feel will add value to the final HTP application. The UCHHealth contact names and email address are available on the first page of this application.



## Additional Information (Optional)

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

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

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

We do not have additional information.



## Appendix I: Community Inventory Tool<sup>1</sup>

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

The hospital is not yet open.

Provider or Agency	Transitional Care Services [Examples]	Yes	No
Community health centers, federally qualified health centers		<input type="checkbox"/>	<input type="checkbox"/>
Accountable care organization with care management or transition care		<input type="checkbox"/>	<input type="checkbox"/>
Medicaid managed care organizations		<input type="checkbox"/>	<input type="checkbox"/>
Program of All-inclusive Care for the Elder (PACE), Senior Care Options (SCO), Duals Demonstration providers		<input type="checkbox"/>	<input type="checkbox"/>
Medicaid health homes		<input type="checkbox"/>	<input type="checkbox"/>
Multiservice behavioral health centers, including behavioral health homes		<input type="checkbox"/>	<input type="checkbox"/>
Behavioral health providers		<input type="checkbox"/>	<input type="checkbox"/>
Substance use disorder treatment providers		<input type="checkbox"/>	<input type="checkbox"/>
Heart failure, chronic obstructive pulmonary disease (COPD), HIV, dialysis, or cancer center clinics		<input type="checkbox"/>	<input type="checkbox"/>
Pain management or palliative care		<input type="checkbox"/>	<input type="checkbox"/>
Physician/provider home visit service		<input type="checkbox"/>	<input type="checkbox"/>
Skilled nursing facilities		<input type="checkbox"/>	<input type="checkbox"/>
Home health agencies		<input type="checkbox"/>	<input type="checkbox"/>

<sup>1</sup> 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
Hospice		<input type="checkbox"/>	<input type="checkbox"/>
Adult day health		<input type="checkbox"/>	<input type="checkbox"/>
Public health nurses		<input type="checkbox"/>	<input type="checkbox"/>
Pharmacies		<input type="checkbox"/>	<input type="checkbox"/>
Durable medical equipment		<input type="checkbox"/>	<input type="checkbox"/>
Other		<input type="checkbox"/>	<input type="checkbox"/>

### Social Services

Provider or Agency	Transitional Care Services [Examples]	Yes	No
Adult protective services		<input type="checkbox"/>	<input type="checkbox"/>
Area Agency on Aging (AAA)		<input type="checkbox"/>	<input type="checkbox"/>
Aging and Disability Resource Centers		<input type="checkbox"/>	<input type="checkbox"/>
Assisted living facilities		<input type="checkbox"/>	<input type="checkbox"/>
Housing with services		<input type="checkbox"/>	<input type="checkbox"/>
Housing authority or agencies		<input type="checkbox"/>	<input type="checkbox"/>
Legal aid		<input type="checkbox"/>	<input type="checkbox"/>
Faith-based organizations		<input type="checkbox"/>	<input type="checkbox"/>
Transportation		<input type="checkbox"/>	<input type="checkbox"/>
Community corrections system		<input type="checkbox"/>	<input type="checkbox"/>
Other		<input type="checkbox"/>	<input type="checkbox"/>



## Appendix II: Hospital Care Transitions Activities Inventory Tool<sup>2</sup>

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

<b>ADMINISTRATIVE ACTIVITIES/ASSETS</b>	<b>For Which Patients?</b>
<input type="checkbox"/> Specified readmission reduction aim	None, hospital is not open yet
<input type="checkbox"/> Executive/board-level support and champion	None, hospital is not open yet
<input type="checkbox"/> Readmission data analysis (internally derived or externally provided)	None, hospital is not open yet
<input type="checkbox"/> Monthly readmission rate tracking (internally derived or externally provided)	None, hospital is not open yet
<input type="checkbox"/> Periodic readmission case reviews and root cause analysis	None, hospital is not open yet
<input type="checkbox"/> Readmission activity implementation measurement and feedback (PDSA, audits, etc.)	None, hospital is not open yet
<input type="checkbox"/> Provider or unit performance measurement with feedback (audit, bonus, feedback, data, etc.)	None, hospital is not open yet
<input type="checkbox"/> Other:	N/A

<b>HEALTH INFORMATION TECHNOLOGY ASSETS</b>	<b>For Which Patients?</b>
<input type="checkbox"/> Readmission flag	None, hospital is not open yet
<input type="checkbox"/> Automated ID of patients with readmission risk factors/high risk of readmission	None, hospital is not open yet
<input type="checkbox"/> Automated consults for patients with high-risk features (social work, palliative care, etc.)	None, hospital is not open yet
<input type="checkbox"/> Automated notification of admission sent to primary care provider	None, hospital is not open yet
<input type="checkbox"/> Electronic workflow prompts to support multistep transitional care processes over time	None, hospital is not open yet
<input type="checkbox"/> Automated appointment reminders (via phone, email, text, portal, or mail)	None, hospital is not open yet

<sup>2</sup> 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>



<b>HEALTH INFORMATION TECHNOLOGY ASSETS</b>	<b>For Which Patients?</b>
<input type="checkbox"/> Other:	N/A

<b>TRANSITIONAL CARE DELIVERY IMPROVEMENTS</b>	<b>For Which Patients?</b>
<input type="checkbox"/> Assess "whole-person" or other clinical readmission risk	None, hospital is not open yet
<input type="checkbox"/> Identify the "learner" or care plan partner to include in education and discharge planning	None, hospital is not open yet
<input type="checkbox"/> Use clinical pharmacists to enhance medication optimization, education, reconciliation	None, hospital is not open yet
<input type="checkbox"/> Use "teach-back" to improve patient/caregiver understanding of information	None, hospital is not open yet
<input type="checkbox"/> Schedule follow-up appointments prior to discharge	None, hospital is not open yet
<input type="checkbox"/> Conduct warm handoffs to post-acute and/or community "receivers"	None, hospital is not open yet
<input type="checkbox"/> Conduct post discharge follow-up calls (for patient satisfaction or follow-up purposes)	None, hospital is not open yet
<input type="checkbox"/> Other:	N/A

<b>CARE MANAGEMENT ASSETS</b>	<b>For Which Patients?</b>
<input type="checkbox"/> Accountable care organization or other risk-based contract care management	None, hospital is not open yet
<input type="checkbox"/> Bundled payment episode management	None, hospital is not open yet
<input type="checkbox"/> Disease-specific enhanced navigation or care management (heart failure, cancer, HIV, etc.)	None, hospital is not open yet
<input type="checkbox"/> High-risk transitional care management (30-day transitional care services)	None, hospital is not open yet
<input type="checkbox"/> Other:	N/A

<b>CROSS-CONTINUUM PROCESS IMPROVEMENT COLLABORATIONS WITH:</b>	<b>FOR WHICH PATIENTS?</b>
<input type="checkbox"/> Skilled nursing facilities	None, hospital is not open yet
<input type="checkbox"/> Medicaid managed care plans	None, hospital is not open yet
<input type="checkbox"/> Community support service agencies	None, hospital is not open yet
<input type="checkbox"/> Behavioral health providers	None, hospital is not open yet
<input type="checkbox"/> Other:	N/A



