The Office of eHealth and Innovation (OeHI) and the eHealth Commission Care Coordination workgroup have done extensive research to understand the current state of care coordination in Colorado. The established goal of the care coordination workgroup is to identify, understand, and prioritize leverage points to support whole person care by facilitating the connection of individuals to needed resources across Colorado communities using health IT infrastructure and data sharing. The workgroup defines whole person care as being comprehensive of both health and social services. To date, the care coordination workgroup activities include the adoption of a Social Health Information Exchange White Paper, an Environmental Scan, development of a Complex System Mapping, and a recent presentation to Public Health on the Rockies on building a Social-Health Information Exchange infrastructure. The visual below depicts the key structural components for

Based on these activities OeHI aims to connect healthcare, human services, and community partners to build an infrastructure for navigating health and social resources, hereafter referred to as a social-health information exchange (SHIE) infrastructure. Investing in SHIE infrastructure would require advancing multiple components simultaneously, including advancing shared practices for data governance, common workflows across collaborating organizations, and the adoption of interoperable technology. The overall vision of the infrastructure is to allow multiple entities to screen, assess and refer clients to resources, ensure clients access resources, provide case management (when applicable), and evaluate the impact of resources on health and wellbeing, as well as the ROI across systems.

The infrastructure and technological solution(s) are envisioned as a person-centered network that includes a robust statewide resource directory or marketplace, minimal platforms for referral and care coordination, and functionality to track connections and outcomes. For more detail please refer to the Social Health Information Exchange White Paper.

Characteristics of an ideal system include:

- System allows both clients (self-seeking) and providers to easily identify and access community-based services – technology platform is user-friendly and interoperable with existing tools
  - Eligibility and enrollment requirements can integrate into the platform
- System tracks client information and allows for clear and effective case management – technology platform provides a feedback loop to providers on the outcomes of referrals
- Appropriate privacy and security functionality protect client information
- System allows data to be gathered on availability and capacity of services within the community
- System includes a sustainable process for updating and maintaining a resource directory (or other comparable solution) and manage system users
- System accommodates multiple primary users, including (but not limited to) medical providers, community-based organizations, clients, policy and system administrators
- System supports analysis of population level outcomes and provides valuable information for decision making and calculation of cost savings
- System is supported by sustainable funding sources or an embedded business model
- System adopts and utilizes data standards that allow for broader interoperability and scalability over time
- System leverages prior investments made in HIT infrastructure and aligns with state driven efforts to increase interoperability across agencies

Many efforts are underway in CO, including both for-profit companies and grant funded pilots, to bring disconnected partners together and connect clients to resources. The Office of eHealth Innovation is looking to fund eligible entities under HITECH guidelines to advance social health information projects and support whole person-care coordination. The goal of this funding strategy is to advance and connect the required components of the infrastructure, reduce duplicative technology systems, and facilitate information sharing within local communities. Recognizing that many initiatives are currently underway to support and enhance interoperability for whole person care, the goal of this funding strategy is to target areas of investment that leverage prior investments, specifically the use of HIEs, and that align with current efforts, specifically the Joint Agency Interoperability project. The grant application process with identify key requirements for use of HIEs and JAI protocols.
Phased Approach

The creation of a robust social-health information exchange system will likely take several years. The funding strategy outlined below proposes that the overall strategy for expansion of a statewide SHIE system would be approached in two phases. This memo primarily focuses on the first phase of development and implementation and the use of HITECH funds. Technology infrastructure may be sustained through MMIS funding, however other funding streams may need to be considered for other elements of the work. Regions across Colorado will be in different stages of readiness for adoption making it likely that some early phase activities will continue into phase two.

- Design Phase (4-6 Months) will focus on readiness of communities and a selection process
- Phase One (Years 1 and 2) will focus on developing partner networks, governance, and implementation
- Phase Two (Years 3 – 5) will focus on scalability and evaluation of patient outcomes and cost savings.

During the design phase OeHI will develop a comprehensive grant opportunity for distributing $5-6M HITECH Funds to selected communities for phase one implementation activities. Lead applicants must demonstrate that they meet criteria for eligibility under HITECH funds, have a track record and capacity for delivery effective technology solutions, and have the capacity to share data with Colorado Health Information Exchanges. The following investment areas will be incorporated into the grant opportunity requirements to further guide the effective use of funds.

Investment Areas

1. **Technology Infrastructure (Core Components) of Social Health Information Exchange** – Funding for core components will target the enhancement of existing technology tools and infrastructure, including:
   - Screening protocols/tools
   - Community resource inventory
   - Closed loop referrals
   - Case management platform(s)
   - Consent management
   - Data exchange schema and standards
   - Data warehousing and security
   - Data analytics

2. **Community Practices** – Funding for community practices will target the implementation of strategies to address shared goals across multi-sector partners and the adoption of local/state data governance standards, including:
   - Convening
   - Planning and project management
   - Tracking and evaluation
   - Legal review and development of MOUs/ data sharing agreements/ ROIs
   - Consumer engagement activities
3. **Change Management (Technical Assistance)** – Funding for change management will target the development of best practices, cross-site learning, and financial sustainability planning, including:
   - Documentation of lessons learned
   - Guidance documents, webinars, technical assistance
   - Cross-site convening
   - Financial modeling and planning

4. **Data Governance** – Funding for data governance will target the alignment of data governance activities across state initiatives and locally funded communities.

   Data governance activities are needed at both the macro and micro level. Some activities will need to occur at the local community level and will require building trust and understanding between cross-sector partners. Other activities will need to occur at the state level and be communicated to community-based partners to achieve alignment. OeHI intends to support the creation of a state level data governance committee with additional technical support provided to communities implementing data governance and continuous alignment with state guidance.

5. **Incentive Payments** – Currently UNFUNDED

   The most consistent concern we hear from stakeholders is that community-based organizations are not financially incentivized to participate in social-health information exchange and care coordination activities. To demonstrate improved outcomes for Medicaid clients, incentive payments may be required to ensure participation in the overall system. The OeHI team intends to explore partnerships with other funding entities to identify opportunities for aligning funding streams that may be used to support community-based organization services.

**Funding Allocations**

Given the number of existing efforts in Colorado focused on the development of SHIE infrastructure and whole person care practices and the limited resources currently available through HITECH funding, OeHI is required to assess the potential trade offs of different funding approaches. The section below outlines four key priority considerations OeHI will use to allocate funding within the grant application process.

1. **Stage of development** – to support optimal use of limited funds OeHI will allocate larger amounts of funding to organizations that have demonstrated their ability to operationalize SHIE infrastructure and practices. Earlier stage solutions are a higher risk for funding and increase the likelihood of duplication across the state. Applications will be categorized in three stages during a review process. Fifty percent of funding will go to established models, thirty percent of funding will go to established concepts, and twenty percent of funding will go to conceptual or demonstration projects.
2. Colorado Region – to support the optimal use of limited funds OeHI will regionally allocate funds to demonstrate the viability of SHIE intrastate in multiple contexts of Colorado. Taking into consideration the higher cost of Medicaid clients in different regions of the state and the higher barriers to accessing care in rural areas, OeHI will skew the funding towards supporting rural/frontier areas geographies.

- 40-50% of funding will be allocated to urban
- 50-60% of funding will be allocated to rural/frontier


3. Alignment with priority areas – to support the optimal use of limited funds OeHI will limit the allocation of funds to projects that align with key priority areas previously identified by state agencies administering services related to whole person care. Additionally, grant applicants will be rated on their ability to leverage previous or existing state efforts including the Hospital Transformation Project, eCQMs, Regional Health Connectors, etc. Key priority areas include:
  - Improved maternal/child health outcomes
  - Coordination for mental health services/ suicide prevention
  - Increased food security
  - Decreased homelessness/ housing instability
  - Coordination for aging services and planning
  - Reduced recidivism rates in criminal justice system
Opioid Abuse Prevention

4. **Demonstrated capacity for interoperability** – to leverage previous state investment and support the optimal use of limited funds, OeHI will limit the allocation of funds to projects that can demonstrated data sharing with state Health Information Exchanges and align with the Joint Agency Interoperability project. Data sharing must meaningfully contribute to the overall ability for effective reporting and data analysis of care coordination activities.

**Grant Application Criteria**

In addition to the four priority considerations outlined above the following criteria will be used to assess grant applications and make funding determinations. The criteria below *may not* be required but will be used to score the overall quality of an application. Additional criteria will be identified and further refined during the design phase.

- Number of participating sectors – higher scores will be given to applicants that can demonstrate data exchange among multiple sectors (healthcare, human services, public health, community-based nonprofits, other care providers)
- Use of a recommended screening tool or validated SDOH question – higher scores will be given to applicants that can demonstrate the ability to integrate a recommended screening tool into electronic workflows
- Ability to perform closed loop electronic referrals to resources that address improvement goals - higher scores will be given to applicants that can demonstrate the capacity to create Role Based Access that assigns users to roles and rights to view, update or modify information
- Comprehensive security measures and practices that ensure protection of client information
- Plans for scalability including processes for documentation of lessons-learned
- Utilization of a comprehensive resource directory that meets national quality control standards
- Timeline and goals for phased rollout, including number of screens and referrals within the two years of the grant period
- Lead applicant can demonstrate prior experience and success with building community coalitions and partner networks

**Enhanced Funding Needs**

The success of a SHIE infrastructure, in part relies on the ability of various service providers to meet the demand of clients. As systems are built and increased screening and referral occurs many communities may face limits to their overall carrying capacity for community-based resources. The parameters of HITECH funding limit our current ability to distribute funds to directly cover the costs of services. However, based on extensive conversations with community partners, we hope to explore additional funding partnerships that could be leveraged to support the delivery of services by partners that are engaging in SHIE infrastructure and practices.

**Conclusion**

The goal of this funding strategy is to advance and connect the required components of the infrastructure, reduce duplicative technology systems, and facilitate information sharing. During a design phase OeHI will further refine the funding approach with the guidance of a taskforce of 5-8 key
stakeholders. It is anticipated that final awards will be made in Summer/Fall 2020 for a two-year grant period.

APPENDIX A. IAPD – Care Coordination Requirements

Proposed Solution IAPD

Funding requested to cover costs for:

- DDI of projects to support whole person care including:
  - Expansion and support of existing community programs
  - Development of referral, resource and screening tools
  - Creation of a legal framework for sharing data
  - Development of a technical infrastructure, including assessment of current functionalities, for sharing data

- Addresses the long-term goal of creating an infrastructure to exchange social health information in support of whole person care supporting and the short-term goal of developing HIT tools and HIE infrastructure

Colorado’s Roadmap indicated the following outcomes for care coordination:

- Strengthened statewide approach to care coordination.
- Timely, appropriate, and easily accessible information is available at the point of care/care coordination – within and across communities – that supports optimal clinical, service, and cost outcomes.
- Criteria to measure care coordination capability and effectiveness by community is available and used.

As an identified priority by the eHealth Commission, work has been accomplished to identify the needs through the environmental scan, workgroup meetings and continued conversations with stakeholders. Key comments from the environmental scan included:

- Need legal framework for sharing data with community organizations and sensitive data across continuum of care.
- Promote consent efforts to identify centralized way to manage consent across organizations and data sets.
- Engage in cross-organizational collaboration and help prioritize technology, population health and care coordination needs/goals.

Additionally, it was discovered that at the community level, services had been developed to meet the unique needs of the individuals seeking service. As a result, workgroup members and the eHealth Commission strongly support utilization and leverage of those resources as appropriate versus creation of “net new” services. Work will also focus on helping organizations have the infrastructure, skills and resources necessary to transform and improve for service delivery.
For FFY 20 and 21, efforts will be to plan and design strategy for aligning and advancing community efforts for coordinating whole person care. Activities and projects will be aligned with leveraging the agreed upon infrastructure and governance for a statewide social health information exchange.

Planned projects include:

- Development of a readiness assessment tool to identify communities that can meet defined criteria for funding.
- Design of a legal and technical framework for sharing between the two HIEs, community partners, state agencies and supporting patient driven exchange.
- Definition and creation of a resource directory to assist individuals in identifying and accessing social services at the community and state level.
- Development of a standardized screening tool that can be used across agencies capturing relevant information that can be shared through existing HIE infrastructure, developed capabilities and/or patient driven exchange through APIs.
- Design of a referral system utilizing the developed screening tool and resource directory to facilitate movement of individuals ensuring that necessary services are received.
- Design of a project funding model to support community and other identified efforts.
- Development of a needs assessment tool that can help community organization prioritize areas of need for technology, workflows and process improvement expertise.
- Technical assistance availability to community programs to ensure that standards and policies are being followed, providing support for projects to be leveraged in other communities or statewide and assist in navigating additional connections and data points.
- Development of interoperability and data standards that will allow community programs, HIEs, and state agencies to share information and that will support patient driven exchange.
- An ongoing evaluative process measuring success based on prescribed metrics and sharing lessons learned and best practices throughout the state.

Across all projects, in conjunction with OeHI’s PMO, metrics will be developed to measure success, capture lessons learned, and best practices for continued statewide expansion. Care Coordination programs will be designed and developed in such a way that Colorado will have a more connected organizational model with projects supporting Colorado’s overall mission and goals for whole person care all resulting in more effective use of resources and as a result higher quality outcome for all.