EHEALTH COMMISSION MEETING

DECEMBER 12TH, 2018
## DECEMBER AGENDA

### Call to Order
- Roll Call and Introductions
- Approval of November Minutes
- December Agenda and Objectives
  - *Marc Lassaux, Co-Chair*
  - *Chief Technology Officer, QHN*

### Announcements
- **OeHI Updates**
- Updates, Grant Opportunities, Workgroup Updates, Announcements, Action Items
  - *Carrie Paykoc, Interim Director, Office of eHealth Innovation*
  - *Commission Members*

### Workgroup and Initiative Updates
- **Advance Health Information Exchange Workgroup:**
  - *Marc Lassaux, Chief Technology Officer, QHN*
  - *Kelly Joines, Chief Strategy Officer, CORHIO*
- **Consumer Engagement Workgroup:**
  - *Tania Zeigler, Director, Enterprise Digital Performance*
  - *Carrie Paykoc, Interim Director, Office of eHealth Innovation*
- **Provider Directory:**
  - *Steve Holloway, Branch Chief, Health Access Branch, CDPHE*
  - *Chris Wells, Division Director, Center for Health and Environment, CDPHE*

### New Business
- **Care Coordination Initiative:** Environment Survey Themes
  - *Ann Boyer, MD Chief Medical Information Officer, Denver Health*
  - *Kim Ball, Health Tech Solutions*
  - *Carrie Paykoc, Interim Director, Office of eHealth Innovation*

### Public Comment Period

### Closing Remarks
- Open Discussion
- Recap Action Items
- January Agenda
- Adjourn
  - *Marc Lassaux, Co-Chair*
  - *Chief Technology Officer, QHN*
OeHI UPDATES

- Commission Renewal Process
- Budget Update
- Support ACT

COMMISSION UPDATES

- Others?
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<th>Action Item</th>
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<th>Timeframe</th>
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<tr>
<td>Define Project Funding</td>
<td>OeHI Director/State Health IT Coordinator</td>
<td>Nov 2018</td>
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<td>Proposal Process</td>
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<td>Update quorum bylaws</td>
<td>OeHI Director</td>
<td>Feb 2018</td>
<td>Pending best practices</td>
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WORKGROUP UPDATES
ADVANCING HEALTH INFORMATION EXCHANGE WORKGROUP

KELLY JOINES, CHIEF STRATEGY OFFICER, CORHIO

MARC LASSAUX, CHIEF TECHNICAL OFFICER, QHN
ADVANCE HIE AND DATA SHARING WORKGROUP REPORT OUT

Marc Lassaux, QHN and Kelly Joines, CORHIO
12/12/2018
## INITIATIVES & NEAR-TERM PRIORITY PROJECTS

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<td>Data Access between QHN and CORHIO</td>
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<td>Patient Access</td>
<td>CIIS Access</td>
<td>Medication History</td>
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<td>Directed Exchange - Query Access</td>
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## Initiatives & Priority Projects

### Near Term Priorities - 12 months

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<td>Medication History - Planning</td>
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<td>Terminology Services</td>
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<td>• External - $166,000</td>
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Colorado eHealth Commission
Health Care Consumer Engagement Initiative Briefing

Presented by
Tania Zeigler
Carrie Paykoc

December 12, 2018
Agenda

➢ Project Purpose and Scope
➢ Project Workgroup and Core Team
➢ Key Project Milestones
➢ Project Status and Next Steps
Project Purpose and Scope

Colorado Health IT Roadmap Initiative #2

Initiative #2

“Promote and Enable Consumer Engagement, Empowerment, and Health Literacy”

Project Scope

This project will provide requirements and recommendations relating to *effective tools* and *services* to help Coloradans be more knowledgeable, proactive, and engaged in their health and well-being.
Project Workgroup and Core Team

Carrie Paykoc, Project Director  
Office of eHealth Innovation

Tania Zeigler, Co-Chair  
Kaiser-Permanente

Gary Drews, Co-Chair  
9Health

Adella Flores-Brennan  
Colorado Consumer Health Initiative

Cara Beatty  
SCL Physicians/Health

Evon Halladay  
Consumer and Innovator

Leah Spielberg  
HCPF

Michelle Lueck  
Colorado Health Institute

Mary Anne Leach (?)  
Former Office of eHealth Innovation

Payer Representative  
Open

Sarah Eaton  
HCPF

Laura Kolkman  
Mosaica Partners

Bob Brown  
Mosaica Partners
Submit completed report in May 2019
Project Status and Next Steps

- Project Kick-Off held
- Interviews in progress – Great Response
- Workgroup – First meeting December 20
- Focus Groups – Planning for mid-January
Any Questions
PROVIDER DIRECTORY

STEVE HOLLOWAY, BRANCH CHIEF, PREVENTION SERVICES DIVISION: HEALTH EQUITY AND ACCESS, CDPHE

CHRIS WELLS, DIVISION DIRECTOR, CDPHE
UPDATE

- New funding secured
- Continuing efforts with OIT to leverage state API
- New user interface released
- Roadmap funding request pending further analysis
CARE COORDINATION INITIATIVE: ENVIRONMENT SCAN INITIAL FINDINGS

ANN BOYER, MD CHIEF MEDICAL INFORMATION OFFICER, DENVER HEALTH
CARRIE PAYKOC, INTERIM DIRECTOR, OFFICE OF EHEALTH INNOVATION
KIM BALL, HEALTH TECH SOLUTIONS
Agenda

• Purpose and Approach to Care Coordination Environmental Scan
• Initial Findings and Themes (Positives and Challenges)
• Potential Recommendations
• Next Steps
# Health IT Roadmap Care Coordination Initiative

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<thead>
<tr>
<th>DOMAIN</th>
<th>Stakeholder Engagement &amp; Participation</th>
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<tr>
<td>DESCRIPTION</td>
<td>This initiative will develop, support, and enhance technical approaches that can be used to easily share care coordination information – within and across – communities. The initiative recognizes that approaches to care coordination may be unique to individual communities.</td>
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<tr>
<td>PURPOSE</td>
<td>The purpose of this initiative is to support communities in implementing their own care coordination processes and to provide the tools and support for individuals whose care coordination needs may extend beyond their local community.</td>
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</table>
Health IT Roadmap Care Coordination Initiative Outcomes

• 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
S-HIE White Paper Considered During Interview Process

Social-Health Information Exchange

1) Screening Protocol
   - Screening and Resource Directory

2) Resource Directory
   - Partners
     - Health Care Organizations (IDRs)
     - Care Coordinators and Managers
     - Public (Patients, Clients, Community Members)
     - Case Managers & Counties
     - Community Based Service Providers

3) Pathways to Resource Directory
   - Bidirectional Interoperability
     - Individual Data on Social Health
     - Referral System
     - Information Exchange and Interoperability

Colorado
<table>
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<th>Step</th>
<th>Task Description</th>
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<td>1</td>
<td>Conduct a series of interviews with key stakeholders across the State to assess existing care coordination processes, capabilities, and planned initiatives.</td>
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<td>2</td>
<td>Identify points of synthesis to determine the current &amp; desired future care coordination to support whole person care.</td>
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<td>3</td>
<td>Review findings with the Office of eHealth Innovation (OeHI) and Care Coordination Working Group and present to the eHealth Commission to finalize an inventory of projects/support opportunities for OeHI that will raise care coordination capabilities to support State strategy.</td>
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<td>4</td>
<td>Group projects based on the underlying capacity addressed, allowing for more concise focus on delivering specific capabilities and benefits to the State and participating organizations.</td>
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<td>5</td>
<td>Sequence all projects into phases to effectively manage budgeting, planning, staffing, and execution – based on the prioritized needs of the organizations interviewed and the State.</td>
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“Eighty-six percent of the nation’s $2.7 trillion healthcare spending was dedicated to chronic care management in 2017, according to the CDC. Strong care coordination, patient behavior change, and consideration of the social determinants of health are just three strategies that can help reduce that spending.”
Environmental Scan by the Numbers

- 35 interviews
- ~90 participants
- 10 stakeholder categories
60 minute interview aimed at
- Understanding current health IT, data infrastructure, gaps and opportunities to facilitate whole person care and
- Understanding ways in which the state could support care coordination enhancements

Interview problem statement
- Colorado’s current technology, infrastructure and policies do not support whole person care

Semi-structured questions

Literature review in progress
## Who We Interviewed…

### Counties
- Stefanie Kenny (Boulder County)
- John Green (Boulder County)
- Mary Baydarian (Garfield County)
- Mark Lionberger (Garfield County)

### Public Health
- Liane Jolon (San Juan Basin Public Health)
- Art Davidson (Denver Health)
- Seth Foley (Denver Health)

### Members/Advocacy Organizations
- Tom Rose (Family Voices)
- Javi Dolif (Family Voices)
  *Julie Reiskin (CCDC)

### Rural Health
- Marcy Cameron (Colorado Rural Health Ctr)

### State Agency
- Laurel Karabatsos (HCPF)
- Susan Mathieu (HCPF ACC)
- Ako Quammie (OIT)

### Technology Partners
- Morgan Honea (CORHIO)
- Robert Denson (CORHIO)
- Kelly Joines (CORHIO)
- Mark Carlson (CORHIO)
- Mark Lassaux (QHN)
- Cindy Wilbur (QHN)
- Dr. Rick Pionkowski (Julota)
- Joshua Cast (Julota)
- Michale Schaedel (Julota)
- Jason Greer (CCMCN)
- Kara Doone (CCMCN)
- Jason McRoy (IBM)
- Jim Bernstein (United Way -211)
- Stephanie Sanchez (United Way-211)
- Wade Teichler (United Way-211)
- Fermin Avila (United Way -211)
- Erin Ulric (CDPHE)
- Rachel Hutson (CDPHE)
- Sara Grassmeyer (CDPHE)
- Tracy Miller (CDPHE)
- Alex Erkenbeck (CDPHE)
- Mitch Mize (CDPHE)
- Nikki Collins (CDPHE)
- Doug Bach (HD Consult)
- Nancy Beagle (HD Consult)

### RAE
- Meg Taylor (Region 1)
- Kari Snelson (Region 2)
- Jen Hale-Coulson (Region 2/4)
- Alyssa Rose (Region 2)
- Wayne Watkins (Region 2/4)
- Paula Kautzmann (Region 3/5)
- Marty Janssen (Region 3/5)
- Chase Grey (Region 3/5)
- Joseph Anderson (Region 3/5)
- Cassidy Smith (Region 3/5)
- Krista Beckwith (Region 3/5)
- Jennette Heung (Region 3/5)
- Kiera Hatton (Region 4)
- Alonzo Payne (Region 4)
- Tina McCrory (Region 4)
- Hanna Thomas (Region 6 & 7)
- Amy Yutzy (Region 6 & 7)
- Glenn Smith (Region 6 & 7)
- Tony Olympio (Region 6 & 7)
- Heather Piernik (Region 6 & 7)
- Elizabeth Holden (Region 6 & 7)

*Sent questionnaire via email per request*
Who We Interviewed cont…

**Behavioral Health**
Camille Harding (Office of Behavioral Health, Colorado DHS)

**Health Plan/Payer**
Lauren Ambrozic (Prevention Alliance)
Toria Thompson (UHC)
Kathryn Jantz (RMHP)

**Family Health/Primary Care**
Dr. Justin Wheeler (Clinica)
Luci Hunter (Clinica)
Janet Rasmussen (Clinica)
Dr. Don Nease (UC Denver)

**Hospital/Health System**
Dana Moore (Children’s Hospital)
Dr. Roberta Capp (UC Health)
Melissa Goodwin (SCL Health)
Glenn Most (SCL Health)
Leslie Callahan (SCL Health)
Noomi Hirsch (SCL Health)
Dr Ann Boyer (Denver Health)
Leslie Kephart (Denver Health)
Matt Everhart (Denver Health)
Tiffany Sailler (Denver Health)
Jessica Johnson-Simmons (Denver Health)
Joe Bajek (Centura)
Nancy Phillips (Centura)
Raymond Deloitte (Centura)
Scott Raymond (Centura)

**Long Term Care/LTSS**
Tim Cortez (HCPF)
Ravi Teja Gorti (HCPF)
Steve House (Orchestra Health)
Findings and Themes
Interview Findings/Themes - Positives

During the course of the interviews, we observed several positive themes:

- Excitement about the collaboration and the discussions happening around care coordination, technology, data sharing and social health influencers
- Global recognition that the care team extends into the community and health care is actually dependent on community orgs and needs to support them
- New workforce to support this work—community health workers and trained navigators
- Consensus that we need better policies and tools to “stitch a patient’s experience together” and act on social health influencers
- Appreciation of the effort around harnessing person-level data to perform care management
- Significant efforts underway in policy development and technology realms
- Low hanging fruit in both data sharing and technology connectivity
## Findings/Themes – Overall Challenges

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<tr>
<td>1</td>
<td>Data Governance</td>
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<tr>
<td>2</td>
<td>Legal Framework/Guidance for Data Sharing &amp; Consent</td>
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<tr>
<td>3</td>
<td>Data Standards for PH, BH, &amp; Social Data to Enable Integration Between Data Stores</td>
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<td>4</td>
<td>Data Timeliness &amp; Access</td>
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<td>5</td>
<td>Data Quality</td>
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<tr>
<td>6</td>
<td>Data Vision/Strategy for State</td>
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<tr>
<td>7</td>
<td>Technology Incentives &amp; Assistance</td>
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<tr>
<td>8</td>
<td>Patient/Family &amp; Provider Satisfaction</td>
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<td>Impact Analysis</td>
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1. Lack of data governance across key data sets pushes entities to engage in one-off contracts, MOUs, BAAs to get access needed by many. Need for statewide privacy, security and data sharing agreements. Starting place: leverage CHI SIM governance subcommittee work and begin applying to other state data sets.

2. Need legal framework for sharing data with community organizations and sensitive data across continuum of care (i.e., California’s SHIG). Promote consent efforts to identify centralized way to manage consent across organizations and data sets (e.g., BH PROMIS data).
Challenges – Data Detail

3. Data standards & rules will help inform what systems agree to share data and in what format. Standards will inform system requirements (especially in new procurements) to facilitate data sharing and closed loop communication. Leveraging national standards & exchange protocols will increase HIE-HIE, EHR-HIE, care management/ community systems-HIEs, BIDM to external systems and data store integration.

4. Work with data owners to improve timeliness of data sets and streamline access to them (e.g., consent management). Improve HIE end user experience (e.g., patient matching).
Challenges – Data & Technology Detail

5. Reduce manual clean-up/spend on data cleaning by creating data standards and incentivizing data quality. Also prevent data gaps (e.g., codes excluded from claims because they’re not reimbursable).

6. Create a consensus-built vision for data sharing and incentivize entities that facilitate data sharing and whole person care accordingly to meet state health goals.

7. Financial incentives & technical support are needed to raise floor for technology use and data sharing for specific key groups (e.g., frontier hospitals, community-based organizations, long-term care, county HHS to contribute data and facilitate transitions of care).
Challenges – People-centeredness and Measurement/Sustainability Detail

8. Incorporate consumer/family and provider perspective in data sharing standardization process and innovation.

9. Prioritize data sharing efforts with focus on delivering impact analysis or information to help the state and organizations understand the value proposition and ROI for sharing data—especially social health data.
Care Coordination Initiative
Strategic Plan
Task: Define Whole Person Care for the State of Colorado

• Currently under consideration by Care Coordination Working Group

• Adapting definition from AHRQ as starting point
  “Care coordination involves deliberately organizing a person’s care activities and sharing information among all of the clinical and non-clinical participants concerned with a person's care to achieve safer and more effective care. This means that the person’s needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.”

• Next steps: Create working definition in Q1 2019 and create a visual that articulates evolution from traditional healthcare definition to one that reflects the connection of communities with the person and family (the core care team) at the center.

• Leverage Care Coordination Resource Guide
Task: Facilitate Consensus-built Whole Person Care Vision and Levers to Achieve It

• Key questions for consideration:
  1. What is the best way to structure/facilitate data governance and standards development for Roadmap efforts?
  2. What does alignment look like and cross-pollination across current or new working groups—data governance, care coordination, advancing HIE?
  3. How do we visualize collaboration across working groups?
  4. How we align financing and expand communications into the work?
Community Orgs

- Further define/ work processes
- Prioritize data needs/gaps
- Align data collection with state standards (where available)
- When adopting new technology for data capture and communication, consult state health IT leadership (or published guidance) for direction on common platforms, community, regional and state health and wellness goals and potential funding sources
- Explore more formal partnerships with CBOs offering the same or similar services to leverage for optimizing technology and resources investments

Clinicians

- Engage in cross-organizational collaboration and help prioritize technology, population health and care coordination needs/goals
- When selecting new health IT, evaluate based on state recognized standards (when available) and national data sharing standards adoption (e.g., Commonwell, Carequality)

Technologists

- Adopt common technical standards to support common definitions, products and services using national frameworks and services (e.g., Commonwell, Carequality)
- Embrace open APIs and encourage app development across community to enable data access to myriad end users based on role
- Connect to State Agency data through Mulesoft
- Enlist end users (e.g., practice staff, CBOs, patients) in development planning when appropriate to design workflows to facilitate data sharing/care coordination
- Create, publish and educate end users with use cases regarding product and services
- Make analytics available to physicians and other end users in the workflow
### Initial stakeholder recommendations

#### Government
- Create rules/framework to expedite sensitive and social data sharing to enable coordination where it happens in the community
- Provide funding for technology adoption and transformation services across Community-based Organizations, LTC and HBC
- Fund standards development and interoperability work. It requires constant research, development and engagement.
- Consider requirements for technology vendors receiving state funding to adopt national data sharing frameworks (e.g., Carequality)
- Develop guidance around the growing Community Health Worker workforce and how they can be integrated into health setting and community-based organizations to provider reimbursed services through Medicaid and/or Regional Accountable Entity contracts

#### Payers
- Commit to value-based care and provider adequate support for physicians, including greater reimbursement for preventive services and adjusting workflows to address SDoH in the practice setting.
- Affirm commitment to value-based care through reimbursement for CHWs, and incentives for achieving pop health metrics around “populations of focus” that reach beyond chronic diseases
- Invest in technology infrastructure and supports to take pressure off of PCPs and specialists and spur adoption of care coordination systems for LTC, HBC and Community-based Orgs
- Commit to/continue to share data to support whole person care regardless of churn risk

#### Patients/Family
- Leverage Consumer Engagement Initiative Working Group
- Ensure Patients/Family at the center of care team
- Align with Consumer Engagement Workgroup Efforts
**Initial stakeholder recommendations**

**ACOs & MCOs**
- Analyze gaps in care, populations and potential pilots that could, for example, blend funding for mental health, substance use disorders, and health in select counties.
- Partnering with Medicaid and the RAEs to support whole person care with coordinated health IT.

**Foundations**
- Consider funding technology infrastructure projects to facilitate data sharing across communities.
- Explore opportunities to support learning labs that will focus on planning, research, development and testing of data standards, data sharing protocols and analytics to benefit vulnerable populations.

**Universities**
- Support whole person care by contributing research and clinical expertise to state and community data sharing initiatives.
- Participate in state efforts to create data standards.
- Leverage COLAB’s data linking hub and research
Next steps

• Complete literature review and spreadsheet of key points from stakeholders interviews

• Work with Care Coordination Workgroup to refine initial concepts and recommendations

• Work with eHealth Commission to further refine recommendations, projects and approach

• Complete Scan report

• Determine how to best leverage 10.10.10 methodology for solving “wicked problems” to validate recommendations, projects and approach as well as reach and ROI
Appendix
Sample of semi-structured questions

- What’s working well in care coordination? What’s not?
- If you have a magic wand, what would you want the state to help your organization with when it comes to supporting/enhancing care coordination?
- If you are given a choice, which should be the main focus of the state and the Care Coordination WG now – 1) expanding access to existing technology and tools implemented across the state (e.g., community resources registry, SDoH HIE), 2) driving standardization of care coordination data elements (e.g., goals, actions, 3) assisting with data acquisition from state agencies or other entities, 4) performing data gap analysis or data use planning (around ADT data, for example), other?
- How are you sharing data with other local organizations when coordinating care for different populations (e.g., high risk populations)?
- What are the most critical constraints in terms of internal business/IT capability, systems or resources that affect the current and/or future success of whole person care efforts for your population/s?
- In terms of LTSS initiatives such as TEFT, what should the state think about in planning projects around technology, data sharing and facilitating whole person care?
Sample of environmental scan literature review

- “California’s 1115 Waiver: An Opportunity to Move from Coverage to Whole-Person Care.” JSI Research & Training Institute, Inc.. January 2015.
- “The State of Health: COLORADO’S COMMITMENT TO BECOME THE HEALTHIEST STATE”. May 2013
- Heath. S. “How Non-Clinical Staff Enable Patient Engagement, Care Coordination.” Patient Engagement HIT.
- Stanek, M., Takach, M. “The Essential Role of States in Financing, Regulating, and Creating Accountable Care Organizations.”
CLOSING REMARKS, JANUARY AGENDA, AND ADJOURN

MARC LASSAUX, CO-CHAIR
# JANUARY DRAFT AGENDA

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<td>Approval of December Minutes</td>
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<td>November Agenda and Objectives</td>
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<td><em>Michelle Mills, Chair</em></td>
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| TBD              | 12:55 |

| Care Coordination Initiative: Draft recommendations | 1:25 |

| Public Comment Period | 1:50 |

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<td>Open Discussion</td>
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<td>Recap Action Items</td>
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<td><em>Michelle Mills, Co-Chair</em></td>
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<td>Topic</td>
<td>Presenter</td>
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<td>Shared Practice Improvement Learning Tool (SPLIT) Update</td>
<td>Kyle Knierim, Associate Director of Practice Transformation at the UC Department of Family Medicine</td>
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<td>Julota- Connected Community</td>
<td>Rick Pionkowski, CEO</td>
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