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Meeting Name: Care Coordination Workgroup
Call In: Zoom Link: https://us02web.zoom.us/j/83040429627 (Panelists, please use your individual links sent to your email) Meeting ID: 830 4042 9627 ✆ Call In Number: +1 719 359 4580
Location: Virtual Only
Meeting Materials: Agenda | OeHI Slides | PCCI Slides

Meeting Date: 9/13/2022	**Meeting Time**: 11:00am - 12:00pm

Agenda Topic	Speaker	Time
Welcome and Agenda Overview	Toni Baruti	5 mins
ITN Updates **Gabby Elzinga** ● The procurement process for SHIE is still on track ● We have changed the procurement mechanism from an RFP (request for proposal) to an ITN (invitation to negotiate) ● Made the change because: ○ Timeline- want to get this procurement out as soon as possible and spend ARPA dollars in a reasonable timeframe ○ RFPs have more technical requirements for a specific solution ■ Our system is meant to be flexible and able to accommodate many use cases, so the ITN is a better fit because it can define a problem and see how vendors can build a solution to that problem. ■ Vendors are able to negotiate what they think the best solution to the problem is. ○ RFPs are very front-loaded and the entire scope of work is drafted at the start ■ ITN - more flexible and the negotiations period is used to write the scope of work. Contract negotiation is part of the ITN process. ● Overall timeline for posting the ITN has not changed from when it was an RFP ○ Internal review is 2 weeks behind initial schedule, but this buffer was built into the timeline ○ Starting e-clearance process for approving the document for sending off to CMS in the next week or so pending a few approvals ○ Hoping to have ITN posted by end of November	Gabby Elzinga	5 mins

• Some things are being procured in the ITN that are considered components of SHIE (statewide infrastructure, regional SHIE hubs)
  ○ And some are part of the broader SHIE ecosystem, but not related to this procurement (consent management, identity resolution, community resource inventory, provider directory)
  ■ Statewide infrastructure will link to these solutions, but they will be procured through other mechanisms
 	
• Toni Baruti- This is a great pathway to ensure the success of the project		

Strikeforce Updates
Gabby Elzinga
• Community Resource Inventory
  ○ OeHI team has made a lot of progress in talking to organizations who have CO resource inventories (MHUW 2-1-1, Unite Us, findhelp, CCMCN, Visible Network Labs, Google, Salesforce, Wellsky, 2-1-1 Collaborative, DRCOG, Hunger Free Colorado) to gather information and understand how these resource inventories collect and verify data and interact with each other
  ○ Next step:
  ■ Melissa presenting at upcoming 2-1-1 Collaborative meeting to present our SHIE approach and how we can better engage with this group
  ■ Also digging into data standards – many different standards used for community resource inventories for both program and referral data – we are understanding the landscape before figuring out our interoperability plan
• Provider Directory
  ○ Talked to most of the owners of provider directories in the state ecosystem
  ○ Working with Google on solutioning proposal to figure out how to use Google Search algorithm and Google for Business to standardize provider data across data resources
  ○ Crosswalking inventories of directories to understand overlap/ shared data elements
  ○ Goal is to have “no wrong door” for providers or clients seeking provider data so that regardless of where you go in the state, you will get accurate provider data
  ■ Same for providers updating their data. Currently updating in multiple places, so we are trying to consolidate so that updates in system X also update in system Y.
	Gabby Elzinga	5 mins

PCCI - Data Governance Models **Leslie Wainwright, PCCI-** **Building Connected Communities of Care: A Capabilities Overview** • PCCI Overview ○ We are a nonprofit organization with a strong affiliation with the Parkland Health System in Dallas, TX. We are our own 501c3 that works closely with the hospital and health plans. Parkland is a safety net provider in Dallas. Our work in SDoH came into being a long time	Leslie Wainwright	35 mins

ago. This work continues and there are multiple types of SDoH work here ○ From a capabilities standpoint, we think about a triangulation of different areas of focus and the intersection between SDoH and data science. We use those capabilities around how we use data to facilitate cross-community understanding ○ Have a strong data science capability to build predictive models and provide value locally, regionally, and across TX ○ We have the first closed loop referral management system for SDoH work, which technically competes with findhelp and Unite Us. Sadly left over in the marketplace and now a separate company who licenses the IP from us. No direct governance or work with this solution anymore, but very familiar with the technical infrastructure to build a closed loop referral management system ○ The programmatic work we do - work with 6 sites across TX to build a version of a clinical and community based partnership (ACH models). ○ Analytical tool that serves as a vulnerability dashboard. The online version of this is just in TX, but the analytics can be done on a one-on-one basis outside of TX ○ Served as an evaluator in terms of looking at overall impact and what impact measurement looks like ○ ***Umbrella***- front end readiness assessment work, programmatic design (where CO is now), and how to quantify and measure impact functionally as you move towards whole person health ● We think about these connected community care models as spanning a continuum ○ It's not a destination – you don't need to build an AHC or ACH – it's condition-specific. ■ Who can come to the table who has passion and motivation to address the problem? What is their political clout? How can they move hills and mountains based on what those relationships look like? ○ In CO – how to go from SHIE-oriented infrastructure to a SHIE infrasture to guide program development? ■ Region-specific to see how partners come together, align on goals, and move forward meaningfully ■ The switch to an ITN for more flexibility is paramount ● Questions ○ Toni Baruti- This is great. I'm loving what I'm seeing in this presentation and it seems like it's in alignment with this workgroup. ○ Abigail Tucker - Reiterating that I've worked in this space in several states and your intro in this is really helpful. Getting a broader baseline will help us work more efficiently going forward. ○ Leslie Wainwright- We are pioneers in all of this. We have a guidebook, but there isn't a single recipe to create this. It's still very much a work in progress and that's why our work in TX has been so informative – there is tension between a strong clinical backbone and a strong community based organization who provides the technical backbone. This has been really instructive.		

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- Programmatic Experience
    - We were one of the 3 TX sites for CMS 5-year demonstration project called AHC
        - Intention to build regional clinical community based partners to answer questions around impact on ED utilization and overall cost of care
        - We were one of the top performing sites across all CMS participating organizations despite a lousy start
        - Recently published a paper about this experience:
            - https://catalyst.nejm.org/doi/full/10.1056/CAT.22.0149
            - Important takeaway:
                - This was not a tech solution, but *people helping people through technology*.
                - Importance of building trust and consistency of knowing that someone is going to follow up.
                - Until we build the people piece in and can ensure consistency, goals, and dedicated time to this work, you are not able to effectively move that needle on social or healthcare impact.
- How does this translate to CO work?
    - There are many areas of parallel activity.
        - Governance has so many levels and is the hardest and most essential
            - Federated model with local flexibility and variance but also rolls up to the state-level where there is cohesion and organization
    - Key Areas to Focus On
        - What are we intending to achieve and by when?
        - What is our “North star” social or clinical impact measure?
            - Ask for concrete examples in ITN
        - What's the quid pro quo for the cost of doing business for the handful of measures that you want everyone to share?
            - What does that data taxonomy look like?
        - Governance - conflict adjudication, data governance, local/regional balance, measurement, and sustainability
        - Regional variance
            - Regional readiness assessments: both quantitative and qualitative measures to provide an objective view around maturity
            - Goal- meet a region with a level of maturity where they are and set particular expectations based on that level of maturity
            - Data can help inform comparative need
                - PCCI uses the RUCA urbanization codes and 2 nationally accepted aggregated measures
                    - Area Deprivation Index (ADI) and the Social Vulnerability Index (SVI)
                - Group level analysis on 10 key indicators to paint a picture of SDoH needs by region
                - Can also overlay clinical conditions and overall

density across a range of clinical conditions using CDC Places data to understand disease burden (higher disease burden shows higher need for CBO services)
    - Key Player CBOs
        - Need to look at retention rate, volunteer-to-staff ratio, comfortability with technology, willingness to use closed loop referral management systems, overall caseload, ability to have HIPAA policies in place
        - Different CBOs play different roles
            - It doesn't mean there isn't a seat at the table for anyone who wants to participate, but it means the seats at the table might look a little bit different, and you can manage those expectations
            - Example: Observational engagement in which an organization is able to participate for a year (come to meetings, contribute, brainstorm), but there wasn't any expectation of data sharing
                - Level of commitment is a continuum
                - Fewer restrictions for participation means fewer excluded potential partners
    - Mapping out clinical and community points of entry
        - Outline pathways and points of entry into the system
            - Identify strong and weaker points
        - Create a handful of true patient personas to test how the platform will work
            - Example: project examining missed appointments and root causes (transportation, etc.)
        - Create an example with one of your own use cases
- Questions
    - Gabby Elzinga- I'm hoping we can see the parallels with the way we're approaching SHIE with past work and upcoming procurements. We do share similarities with TX (strong diversity in structures across regions and counties) and we want to leverage the strengths of communities and let those communities drive the work in the way that works for them and their existing networks. And I love the maturity model for letting folks join the network when they are ready – this will stop small CBOs from feeling like this is a mandate
        - Leslie Wainwright- one challenging thing is how to wear so many different hats with various organizations. Need to help everyone switch gears and think about specific requirements for the project at hand
    - Brandon Ward- I am thinking about your work in TX and what this might look like in CO- we are underway with identifying our common technical infrastructure and some governance around that. You emphasized the importance of population health measurement and the benefits of this. What does that look like in CO on the road ahead? Who owns (state agency?) bringing together communities in a way that identifies targets and governs how an organization joins the SHIE and what their level of participation is and what they should

expect. Where will that live? ■ Gabby Elzinga- I would love to hear from HCPF on this. OeHI currently owns this, but given our positioning, that isn't a permanent or sustainable solution. A PM is coming on to lead IT governance to build staff and institutional capacity. ARPA funds are one-time funds, so we have a good opportunity now that we might not get again. What comes next is something we should be talking about now so we can get ahead of it. ■ Abigail Tucker- For this to be successful, it has to be a both/and, not an either/or. The state sets up the infrastructure in a way that is easily sustained and replicated and built upon. But then individuals and communities themselves own it. Need to clarify ownership of process/system vs people and data. Collective ownership is also really important, otherwise it won't be successful. ■ Leslie Wainwright- Given where CO is at in this moment, what are the 5 clinical and non-clinical measures that start getting collected statewide even if it's a local SHIE, making sure it can connect longitudinally to the records. It's not social or clinical needs, but the connection between the two that give whole person insights. ■ Brandon Ward- That begs questions about the sustainability model moving forward and taking lessons from how we have commercialized the HIE in CO and the lessons learned from Contexture and QHN and how tricky this has been for hospitals since they burden the costs for this. Who would fund parts of this? ■ Gabby Elzinga- Coming up with a sustainable business model is paramount for this project. Will likely need some state funding since our clients are the most vulnerable and have the strongest need for social support. There is a case to be made for the state as a payor that we need to work through. We appreciated this about PCCI's model in starting small and giving regions the ability to choose what is important for buy- in and building sustainability and momentum given state staff turnover. Maybe this should be a focus of a future workgroup meeting to get ahead of this before funding is even out the door? ■ Leslie Wainwright- There are a lot of different ways to think about medicaid and funding and strategic facilitation. Governance and financial sustainability take the majority of planning time.		
Public Comment ● No additional comments at this time. ● Follow up comments can be emailed to Gabby Elzinga & Melissa Hensley	Gabby Elzinga	5 mins
Closing, Action Items	Gabby Elzinga	5 mins