OeHI
Office of eHealth Innovation

EHEALTH COMMISSION MEETING

DECEMBER 12TH, 2018

DECEMBER AGENDA

OeHI
Office of eHealth Innovation

Call to Order Roll Call and Introductions Approval of November Minutes December Agenda and Objectives *Marc Lassaux, Co-Chair* *Chief Technology Officer, QHN*	12:00
Announcements OeHI Updates Updates, Grant Opportunities, Workgroup Updates, Announcements, Action Items *Carrie Paykoc, Interim Director, Office of eHealth Innovation* *Commission Members*	12:05
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*	12:25
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*	12:55
Public Comment Period	1:40
Closing Remarks Open Discussion Recap Action Items January Agenda Adjourn *Marc Lassaux, Co-Chair* *Chief Technology Officer, QHN*	1:45

ANNOUNCEMENTS

OeHI Office of eHealth Innovation

OeHI UPDATES

- Commission Renewal Process
- Budget Update
- Support ACT

COMMISSION UPDATES

- Others?

ACTION ITEMS

Action Item	Owner	Timeframe	Status
Define Project Funding Proposal Process	OeHI Director/ State Health IT Coordinator	Nov 2018	In progress
Update quorum bylaws	OeHI Director	Feb 2018	Pending best practices

OeHI
Office of eHealth Innovation

WORKGROUP UPDATES

OeHI
Office of eHealth Innovation

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

1. Broaden & Deepen Data Connections	2. Expand Event Notifications	3. EHR Workflow Integration	4. Expanded Medication Services	5. Data Standardization
Data Access between QHN and CORHIO	Additional Notifications and Triggers	Single Sign On	PDMP	Terminology Services
Patient Access		CIIS Access	Medication History	
Directed Exchange – Query Access				

Near Term Priorities - 12 months	
Project	**Costs**
Data Access between QHN and CORHIO	• HIE – $40,000 • External - $33,000
Patient Access - Planning	• HIE - $60,000 • External – NA
Additional Notifications and Triggers	• HIE - $139,000 • External - NA
Single Sign On	• HIE – $117,000 • External - $175,000
Medication History - Planning	• HIE - $60,000 • External - NA
Terminology Services	• HIE – $186,000 • External - $166,000

OeHI
Office of eHealth Innovation

CONSUMER ENGAGEMENT WORKGROUP

TANIA ZEIGLER DIRECTOR, ENTERPRISE DIGITAL PERFORMANCE

CARRIE PAYKOC, INTERIM DIRECTOR OEHI

OeHI
Office of eHealth Innovation

MOSAICA PARTNERS
Transforming Communities and Organizations Into Healthcare Leaders

Colorado eHealth Commission

Health Care Consumer Engagement

Initiative Briefing

Presented by

Tania Zeigler
Carrie Paykoc

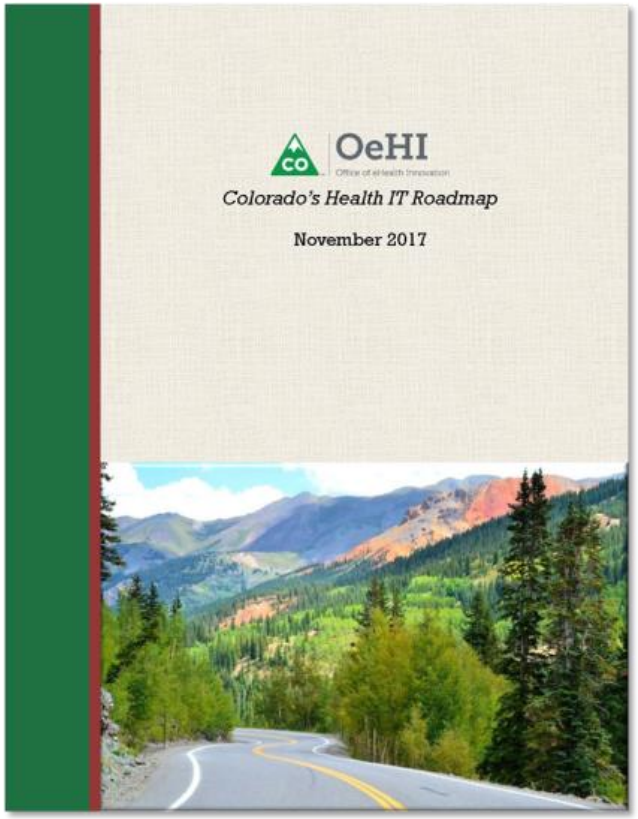
December 12, 2018

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

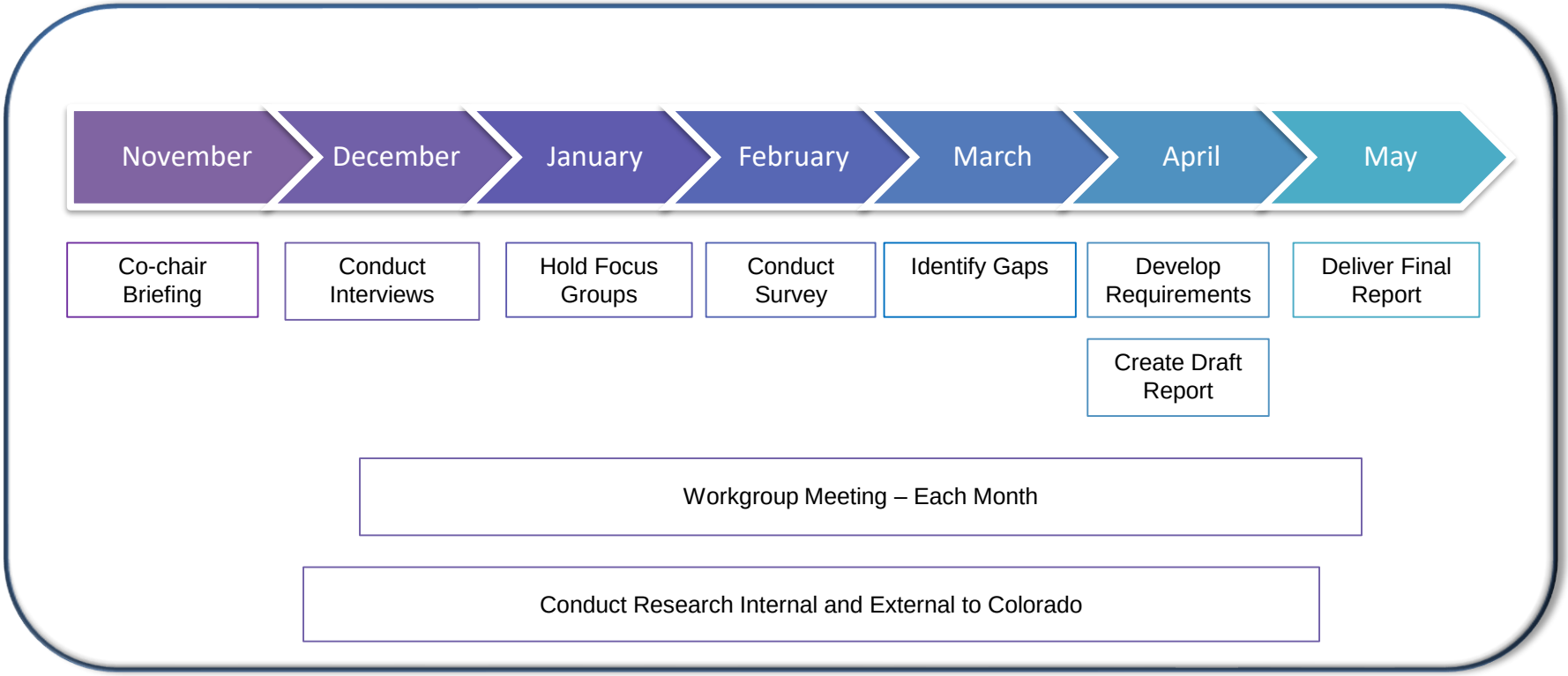
Payer Representative
Open

Sarah Eaton
HCPF

Laura Kolkman
Mosaica Partners

Bob Brown
Mosaica Partners

Key Project Milestones



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

Interviews

Focus Groups


Any
Questions

OeHI
Office of eHealth Innovation

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

OeHI
Office of eHealth Innovation

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

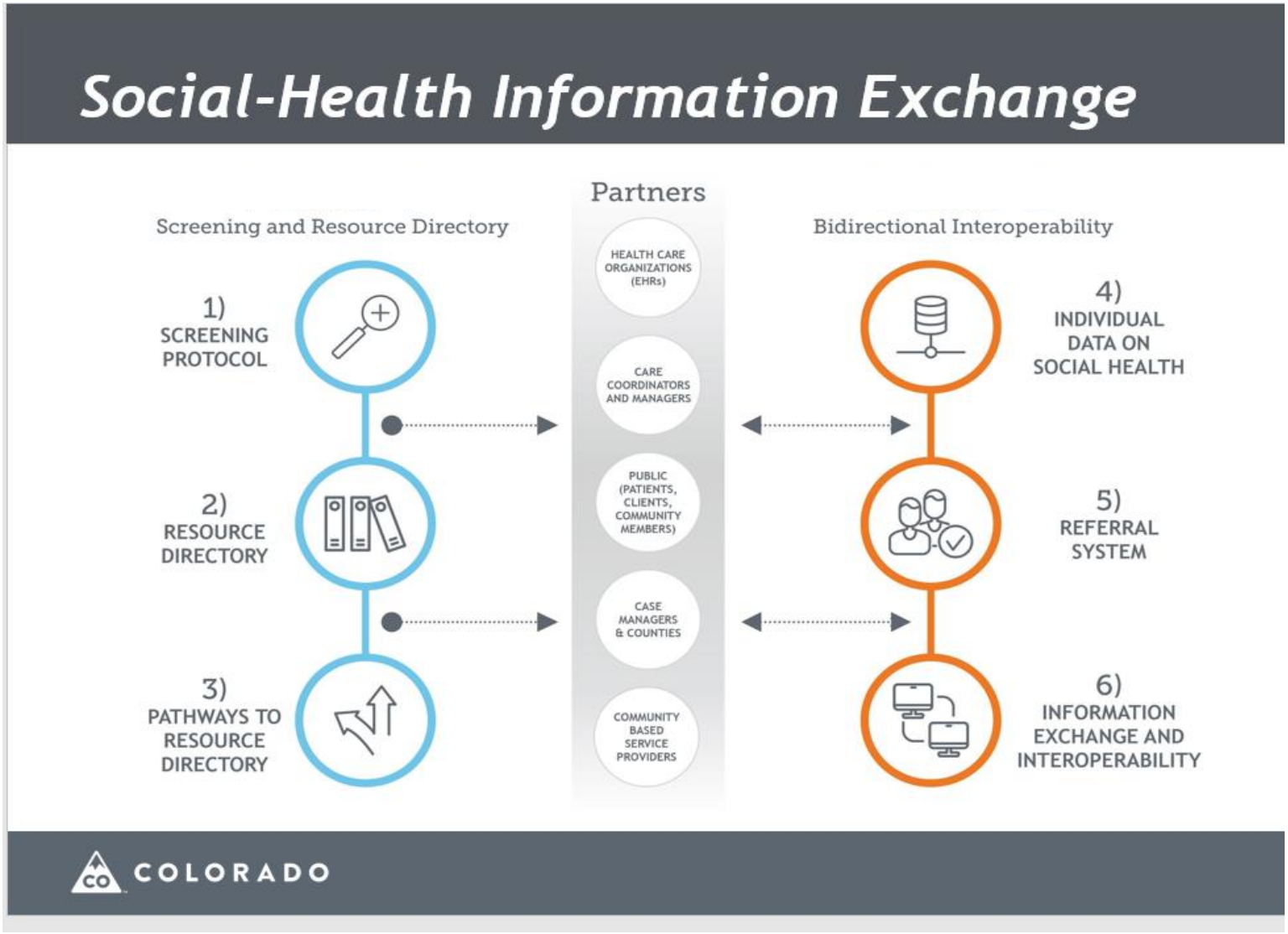
Health IT Roadmap Care Coordination Initiative

DOMAIN	Stakeholder Engagement & Participation
DESCRIPTION	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.
PURPOSE	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.

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



Process for Creating Recommendations

INTERVIEW STAKEHOLDERS	1	Conduct a series of interviews with key stakeholders across the State to assess existing care coordination processes, capabilities, and planned initiatives
QUALITATIVE ASSESSMENT	2	Identify points of synthesis to determine the current & desired future care coordination to support whole person care
IDENTIFY PROJECTS	3	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
ORGANIZE & GROUP PROJECTS	4	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
SEQUENCE PROJECTS	5	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

“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

Environmental Scan Interview Format

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

1. Data Governance
2. Legal Framework/Guidance for Data Sharing & Consent
3. Data Standards for PH, BH, & Social Data to Enable Integration Between Data Stores
4. Data Timeliness & Access
5. Data Quality
6. Data Vision/ Strategy for State
7. Technology Incentives & Assistance
8. Patient/Family & Provider Satisfaction
9. Impact Analysis

Challenges – Data Detail

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?

Initial stakeholder recommendations

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

- "Social Health Information Exchange: Connecting Health Care with Services that Address the Social Determinants of Health." State of Colorado. August 2018.
- "The Future of Electronic Health Records." Stanford University. September 2018.
- "Integrating Data On Social Determinants Of Health Into Electronic Health Records." Health Aff (Millwood). 2018 Apr;37(4):585-590. doi: 10.1377/hlthaff.2017.1252.
- "Addressing Population Health: Integrators in the Accountable Health Communities Model." JAMA. 318(19):1865–1866, NOV 2017.
- "California's 1115 Waiver: An Opportunity to Move from Coverage to Whole-Person Care." JSI Research & Training Institute, Inc.. January 2015.
- "Albritton, E. "How States Can Fund Community Health Workers through Medicaid to Improve People's Health, Decrease Costs, and Reduce Disparities. Families USA, Washington, D.C. July 2016.
- De Yoana, M. "Colorado Fire Department Reduces 911 Calls By Helping Frequent Callers." December 4, 2018.
- Scherpbie, H. Smith, C. Community vitals: The importance of social determinants in population health. Phillips Wellcentive. Alpharetta, GA. 2017
- "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."
- Standardizing Resource Data APIs. https://digitalimpact.org/grants/standardizing-resource-data-apis/
- Oonagh, J. NYC government publishing open data for municipally-contracted service providers. November 8, 2018.

OeHI
Office of eHealth Innovation

CLOSING REMARKS, JANUARY AGENDA, AND ADJOURN

MARC LASSAUX, CO-CHAIR

JANUARY DRAFT AGENDA

OeHI
Office of eHealth Innovation

Call to Order **Roll Call and Introductions** **Approval of December Minutes** **November Agenda and Objectives** ***Michelle Mills, Chair***	**12:00**
Announcements OeHI Updates Updates, Grant Opportunities, Announcements, Action Items *Mary Anne Leach, Director, Office of eHealth Innovation* *Carrie Paykoc, State Health IT Coordinator* *Commission Members*	12:05
New Business	
TBD	12:25
TBD	12:55
Care Coordination Initiative: Draft recomendenations	1:25
Public Comment Period	1:50
Closing Remarks Open Discussion Recap Action Items December Agenda Adjourn *Michelle Mills, Co-Chair*	1:55

POTENTIAL FUTURE AGENDA TOPICS

OeHI
Office of eHealth Innovation

Topic	Presenter	Focus	Scheduled
Shared Practice Improvement Learning Tool (SPLIT) Update	Kyle Knierim, Associate Director of Practice Transformation at the UC Department of Family Medicine	Sustainability post SIM	
Julota- Connected Community	Rick Pionkowski, CEO	Social health information exchange	