OeHI
Office of eHealth Innovation

EHEALTH COMMISSION MEETING

WEB-CONFERENCE ONLY

January 19, 2022

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Office of eHealth Innovation

NOTE:
NEW ZOOM WEBINAR LINK
PASSCODE: ehealth
DIAL IN BY PHONE:
US: +1 669 900 9128
OR: +1 253 215 8782
WEBINAR ID: 858 7399 5343
PASSCODE: 4946171

IF YOU ARE EXPERIENCING AUDIO OR PRESENTATION DIFFICULTIES DURING THIS MEETING, PLEASE TEXT ISSUES TO
203-521-5910

January Agenda

Title	Start	Duration
Open		
Call to Order • Roll Call and Introductions • Approval of December Minutes • January Agenda and Objectives *Michelle Mills, Chair*	12:00	5 mins
Announcements • OeHI Updates-eHealth Commission Updates • Decision Items & Action Items *Lt. Governor Dianne Primavera, Director of the O$PMOHC* *Stephanie Pugliese, Deputy Director, Office of eHealth Innovation (OeHI)* *eHealth Commission Members*	12:05	15 mins
New Business		
eHealth Commission Chair & Vice Chair Nominations and Vote *Stephanie Pugliese, Deputy Director & State Health IT Coordinator, OeHI*	12:20	15 mins
Colorado Health IT Roadmap Implementation and Next Steps *Stephanie Pugliese, Deputy Director & State Health IT Coordinator, OeHI* *KP Yelpaala, eHealth Commission Vice Chair, Chief Executive Officer & Co-Founder, InOn Health*	12:35	10 mins
Care Coordination Future Plans Next Steps: Contexture *Janeece Lawrence, VP of Project Management, Contexture* *Heather Culwell, Director, State Health Initiatives, Contexture* *Stephanie Sanchez, 2-1-1 Statewide Director, Mile High United Way*	12:45	30 mins
Care Coordination Future Plans Next Steps: QHN *Jason McRoy, Director of Analytics, QHN*	1:15	30 mins
Public Comment Period	1:45	5 mins
eHealth Commission Meeting Closing Remarks • Open Discussion • Recap Action Items • Future Agenda Items • Adjourn Public Meeting *Michelle Mills, Chair*	1:50	10 mins

Announcements

OeHI and eHealth Commission Updates

- Rural Connectivity Program
- eHealth Commission Reappointments and New Appointments
- State Health IT Updates
- Commissioner Updates

Note: If you are experiencing audio or presentation difficulties during this meeting, please text 203-521-5910.

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Remarks from Lt. Governor Dianne Primavera

Lt. Governor Dianne Primavera, Director of the Office of Saving People Money on Health Care

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eHealth Commission Chair & Vice Chair Nominations and Vote

Stephanie Pugliese, Deputy Director & State Health IT Coordinator, OeHI

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Colorado Health IT Roadmap Implementation and Next Steps

Stephanie Pugliese, Deputy Director & State Health IT Coordinator, OeHI
KP Yelpaala, eHealth Commission Vice Chair, Chief Executive Officer & Co-Founder, InOn Health

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Care Coordination Future Plans Next Steps: Contexture

Janeece Lawrence, VP of Project Management, Contexture
Heather Culwell, Director, State Health Initiatives, Contexture
Stephanie Sanchez, 2-1-1 Statewide Director, Mile High United Way

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Care Coordination and S-HIE Overview

Creating better-connected care for Colorado communities

Janeece Lawrence, VP Project Management
Heather Culwell, Director State Health Initiatives
Stephanie Sanchez, Senior Director, Statewide 2-1-1
January 19, 2022

Introducing Contexture

Two industry leaders, better together.

CORHIO™ | health current

contexture℠
Creating connections. Improving lives.

NAME MEANING

The meaning of “contexture” refers to **linking different parts together to form a connected whole**. In the same way, Contexture draws together disparate pieces of information from multiple sources to create a clear context for care.

contexture℠
Creating connections. Improving lives.

OUR MISSION

Advancing individual and community health and wellness through the delivery of actionable information and analysis.

Social Health Information Exchange Landscape

- Diverse landscape of platforms
- Lack of technical and financial resources
- Most solutions focus solely on end-user functionality
- Slow to adopt approaches to interoperability
- Duplicative community resource inventories

Our Vision for Colorado Communities

Vision Statement

Leverage and enhancing existing infrastructure such as investments in EMRs, care coordination tools, CORHIO and Mile High United Way 2-1-1, develop an ecosystem of interoperability to support the automated exchange of information between healthcare providers, community organizations, public health, and State agencies.

Goals

- Improve the health and well-being of Colorado communities through better integrated data sharing capabilities
- Leverage and enhance existing local investments
- Develop and support vendor-agnostic infrastructure for a market that has already begun the adoption of diversified toolsets
- Lessen the burden on under-resourced community organizations and initiatives
- Leverage economies of scale to ensure equitable access for underserved communities

S-HIE Approach: One Size Doesn't Fit All

Meeting entities where they are and building a system of systems

Community Resource Model:

Access to and import of a single Community Resource Inventory database into a participant's system using an API or other technologies

SDOH Notifications:

Allows for participants to use their own systems – such as Unite Us or Aunt Bertha while utilizing existing CORHIO connections to leverage additional CRI Data and share information (not the referral itself…yet)

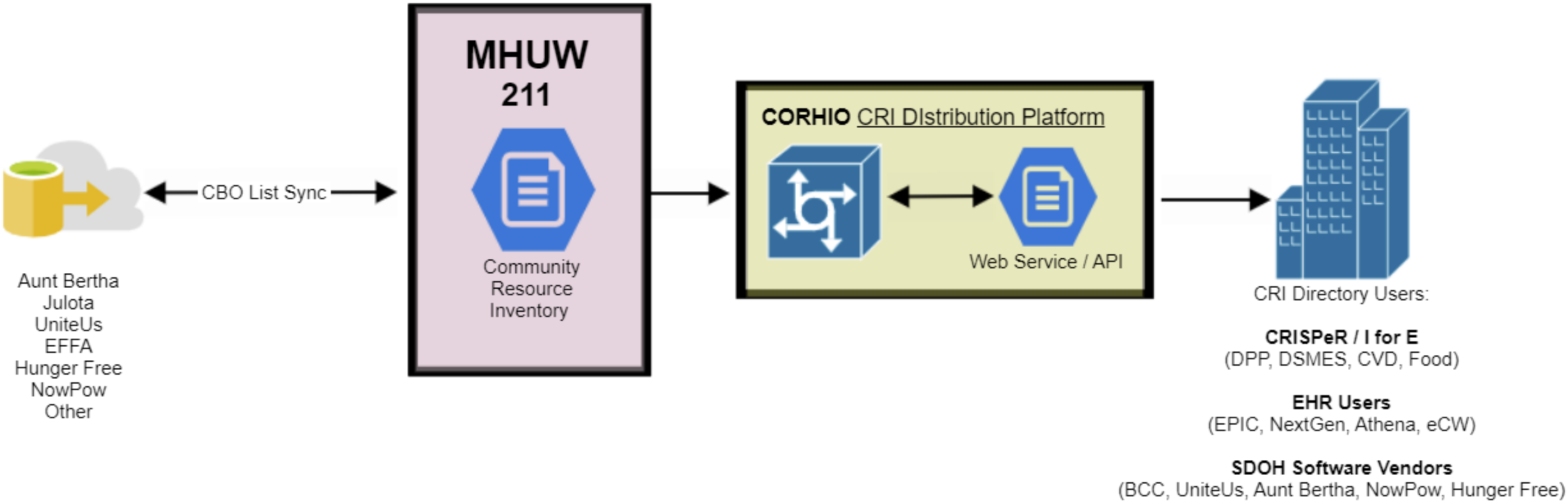
Community Resource Inventory (CRI) Use Case

Scenario: Lisa went in for her annual physical exam and her doctor called her a couple of days later to review her lab results. Her doctor informed her that results indicate she has prediabetes and suggested certain lifestyle changes could help to ensure that this didn't progress to type 2 diabetes. In addition, Lisa's doctor was aware of community organizations who host classes to support individuals with prediabetes. The classes are intended to give individuals the tools, resources, and support they need to successfully implement these key lifestyle changes.

Community Resource Inventory (CRI) Use Case

Workflow: Lisa's doctor opened the Electronic Health Record and initiated a query that went to the Contexture platform. The query included Lisa's diagnosis and her zip code. Contexture returned a list of Community Based Organizations who provide prediabetes services in close proximity to Lisa's home address. Lisa's provider was able to access that list of organizations and share it with Lisa so she can enroll in the next class that works best for her schedule.

Community Resource Inventory (CRI) Distribution



MHUW 2-1-1 CRI Advantages

- CBO Relationship Management
  - One-to-many options to reduce CBO burden of maintaining information in multiple locations

- Data Standardization
  - Services are standardized by use case

- Community Based Organizations (CBO) Portal
  - Self-service portal to manage a CBO's own information and services

- Data Distribution
  - CRI Database lives with Mile High United Way and accessed via API by CORHIO
  - CRI access is distributed via CORHIO to interested partners

  - Mile High United Way Perspective

eReferral Use Case

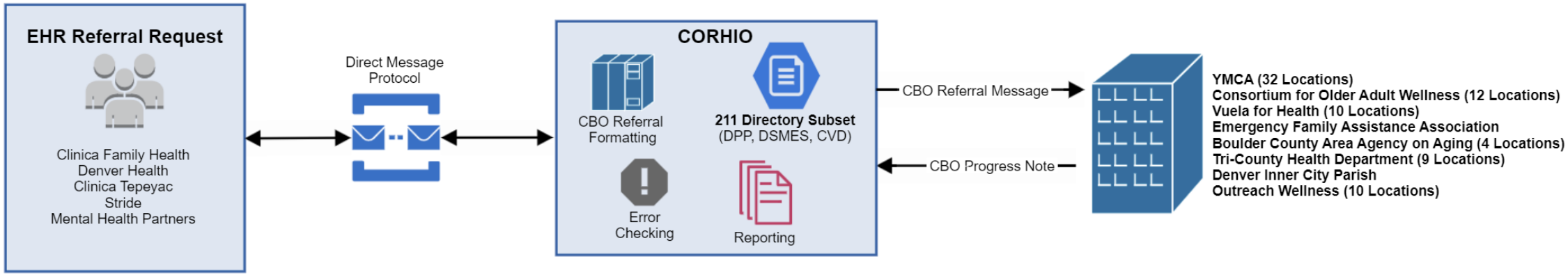
Scenario: Bill hadn't been feeling well for a while, so he made a doctor's appointment. During his visit, his doctor did an exam and drew blood for lab testing. The next day the doctor called Bill to review his lab results and shared concerns that his HbA1C had increased considerably. The doctor felt he may need some additional support in order to successfully manage his diabetes and wanted to recommend services through a local organization that could help by put a customized plan in place aimed at improving his Hba1C.

eReferral Use Case

Workflow: She discussed with Bill which organization was most convenient to him before initiating a referral from the Electronic Health Record. The doctor selected the organization in the EHR referral template and hit send. The EHR is configured to capture Bill's demographics, diagnoses, and insurance information. All of this data is included with the reason for the referral and is added to a Continuity of Care Document that is sent outbound to Contexture via Direct message. Contexture's technology platform determines who the referral needs to go to and delivers it via their preferred method.

By initiating an electronic referral on Bill's behalf, the doctor is confident that the community organization will receive it, act upon it, assess his eligibility for their program, and reach out to Bill directly. Bill has a greater chance of success as a result of the organization reaching out to him directly than having him initiate contact himself.

CORHIO Referral Platform Integration

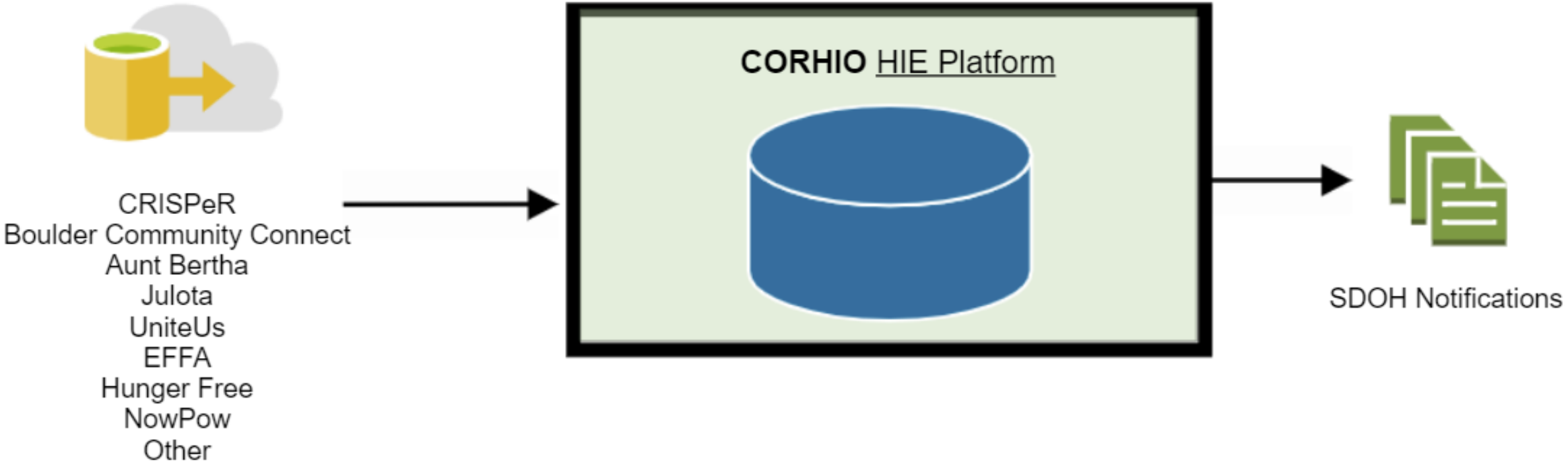


Social Needs Referral Notifications Use Case

Colorado Access - Social Needs Referral Notifications

- Regional Accountable Entity within the Medicaid Accountable Care Collaborative (ACC)
- Alerts when COA ACC members have been referred to a community-based organization by a physician's office
- Supports COA's case management obligations under the ACC including emphasis on patient follow-up and continuity of care
- Saves time searching in multiple systems to determine if a referral was made
- Enhances patient follow-up
- Provides additional support needed to ensure the patient's social needs are being met

SDOH Notifications Model



SDOH Notifications Model

- Includes CORHIO Referral Network and Vendor Partners

- Existing Infrastructure Leveraged CORHIO Platform
- Push Data Model
  - Data routes based on member files
  - Feeds directly into electronic health records system
- Data Types Can Be Added
  - Scalable to new use cases

S-HIE Benefits

- Leverages the pipes already built within the HIE
  - Data flows in and out using existing interfaces
  - Data standards can be leveraged across various data types
  - Promotes creation of comprehensive datasets
- Does not require duplicate data feeds
  - Connections already in place to hundreds of participants
  - Inbound and outbound feeds can be reused
- Allows for one-to-many connections
  - Bringing in data once and distributing many times

Lessons Learned

- Contexture's Care Coordination platform is scalable with the right investments and partnerships but may not meet every use case or need
- Integration with electronic health records system is most preferable for provider - also brings highest cost
- Sustainability is challenging but not impossible
- Referral data volume is low, as such data into the HIE is minimal. Without available data, populating a Notification Alert will be challenging
- Establishing a statewide Community Resource Inventory is complex without standards in place to align across all of the disparate systems being utilized in the ecosystem
- Mile High United Way lessons learned

CommunityCares – Arizona's SDOH Referral System

- Health Current, Arizona's HIE and a Contexture organization, has launched a statewide closed loop referral system for SDOH
- The Arizona Health Care Cost Containment System, Arizona's state Medicaid agency, launched its Whole Person Care Initiative. As part of this strategy, they partnered with Health Current to develop a technology solution that can support providers, health plans, community-based organizations and community stakeholders in meeting the healthcare and social-economic needs of Arizonans.

Upcoming Webinar – Arizona SDOH Network

January 31st at 12-1pm MST

Interstate Innovation: Best Practices in Developing a Social Determinants of Health (SDOH) Referral System
Hosted by Health Current WebEx Meeting Invite

https://healthcurrent.webex.com/healthcurrent/j.php?MTID=mea165280a425067630ba398870412bbf

Please reach out to Katy Reno to be added to the invitation and for details.

katy.reno@contexture.org
Marketing & Communications Manager

Thank you for attending!

Contact Information

janeece.lawrence@contexture.org
heather.culwell@contexture.org
stephanie.sanchez@unitedwaydenver.org

Care Coordination Future Plans Next Steps: QHN

Jackie Sievers – Director of CRN Implementation
Jason McRoy, Director of Analytics, QHN

QHN Whole Person Care Coordination

eHealth Commission Meeting

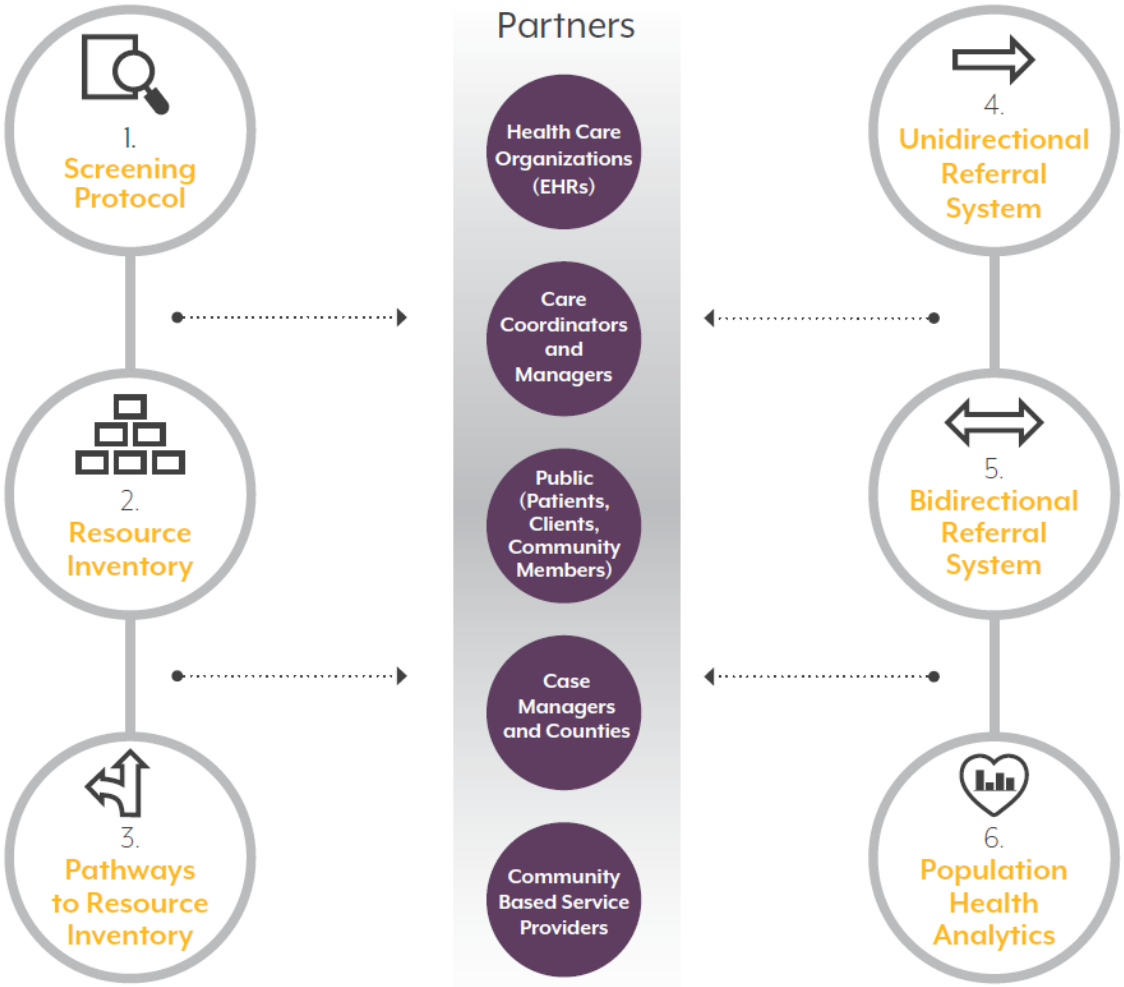
January 19, 2022

Jackie Sievers – Director of CRN Implementation
Jason McRoy – Director of Analytics

Presentation Goals

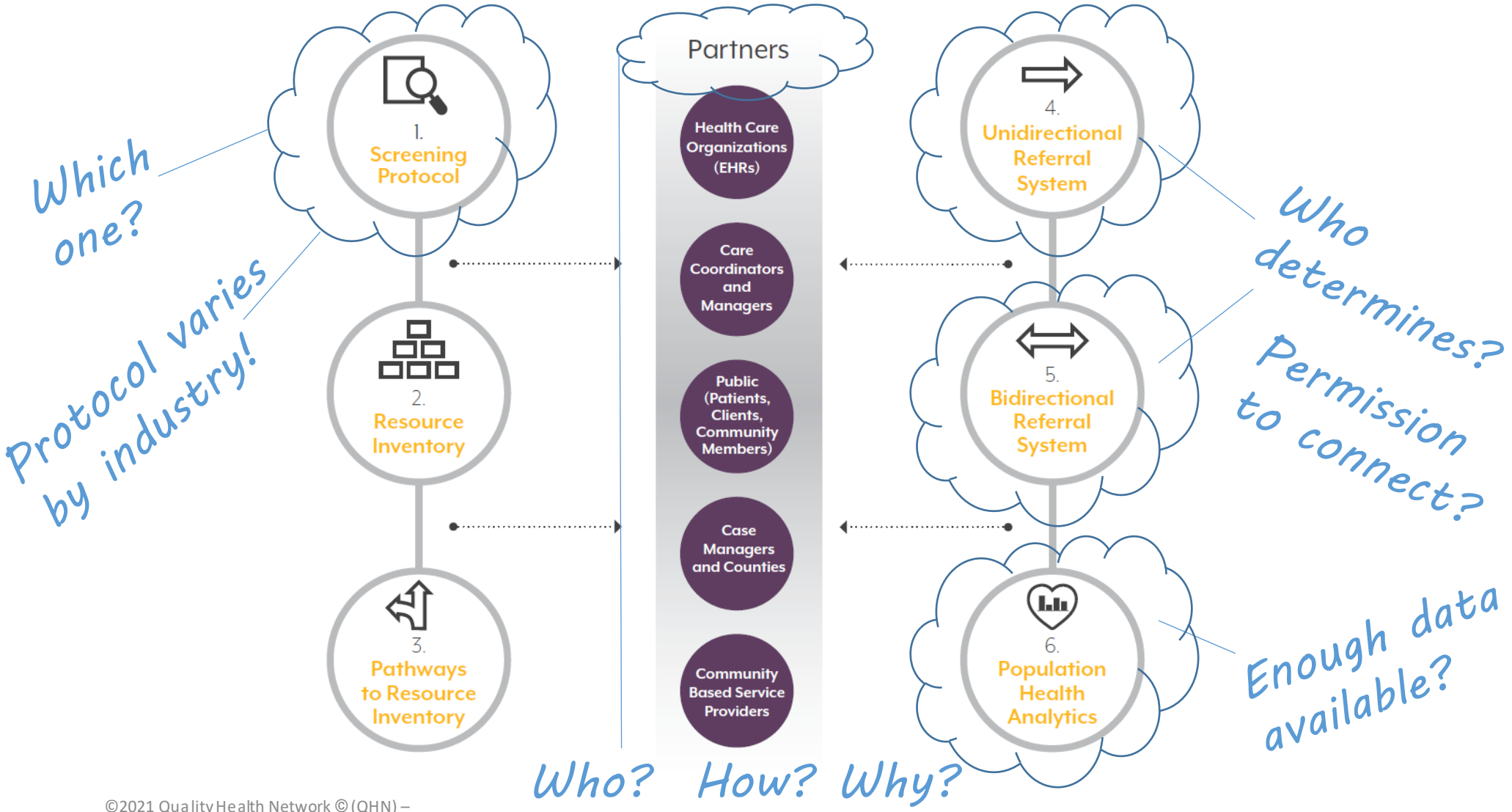
- Overview of QHN approach to implementing Whole Person Health Care Coordination projects
- Community Resource Network (CRN) implementation
- Highlight outcomes and lessons learned to date

6 Elements of S-HIE Implementation



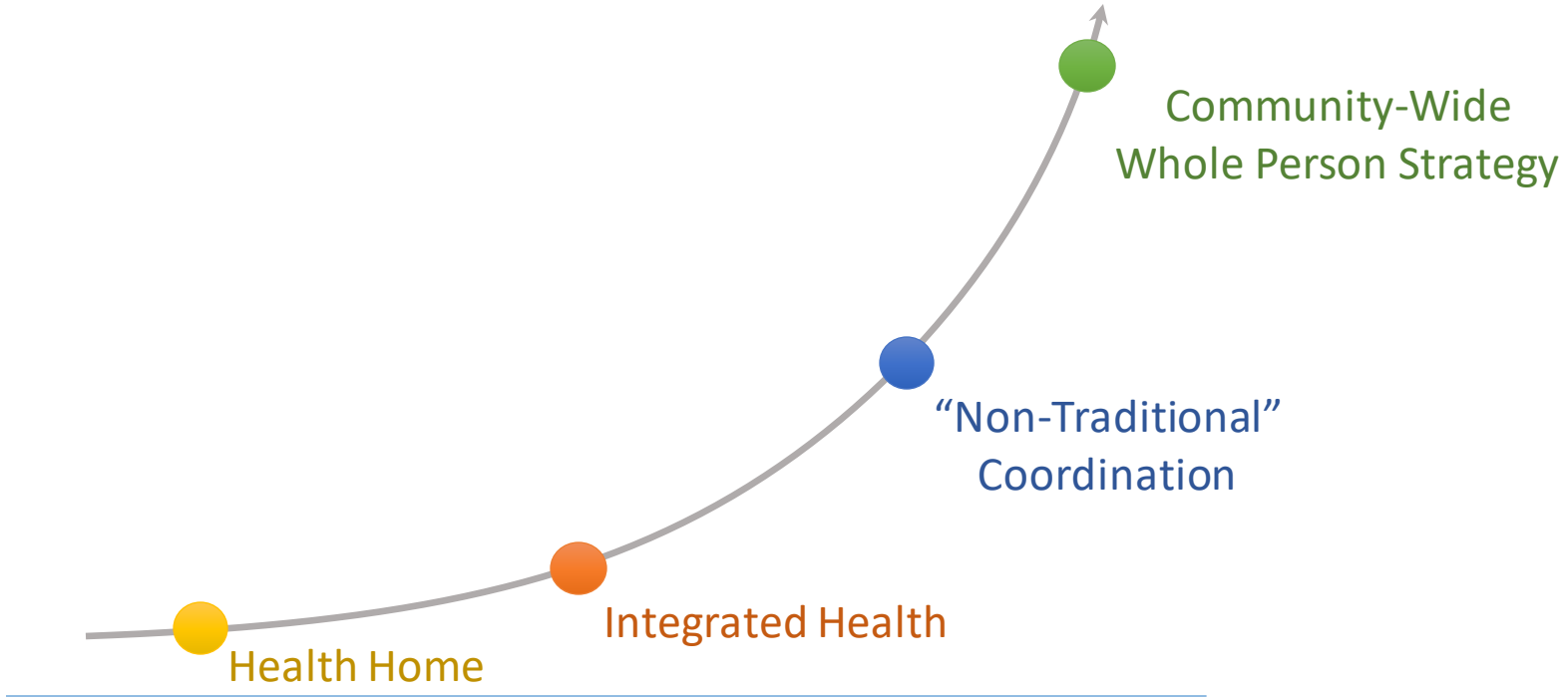
OeHI S-HIE Whitepaper 2021

S-HIE: Can be harder than it looks



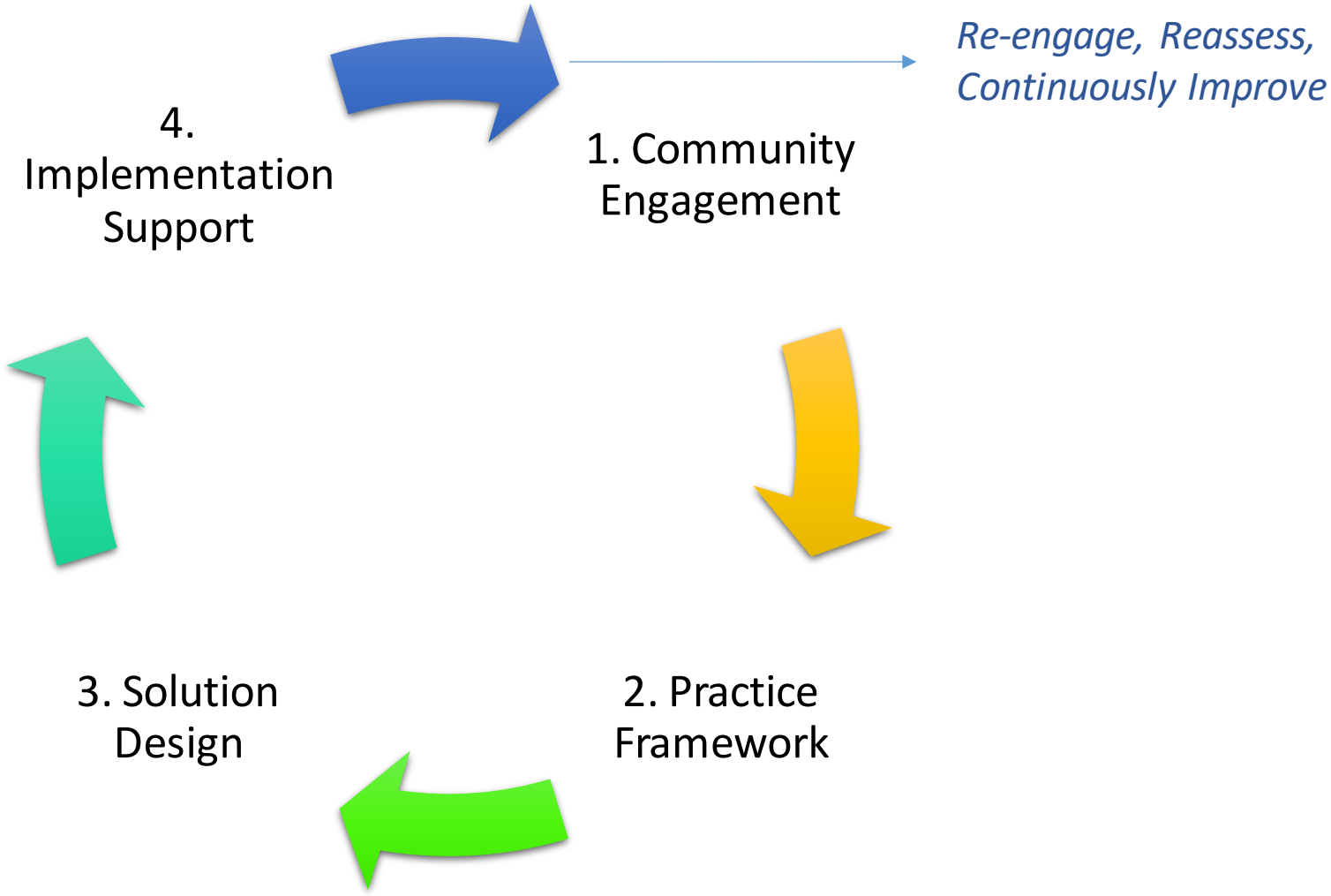
OeHI S-HIE Whitepaper 2021

Care Coordination is a Continuum



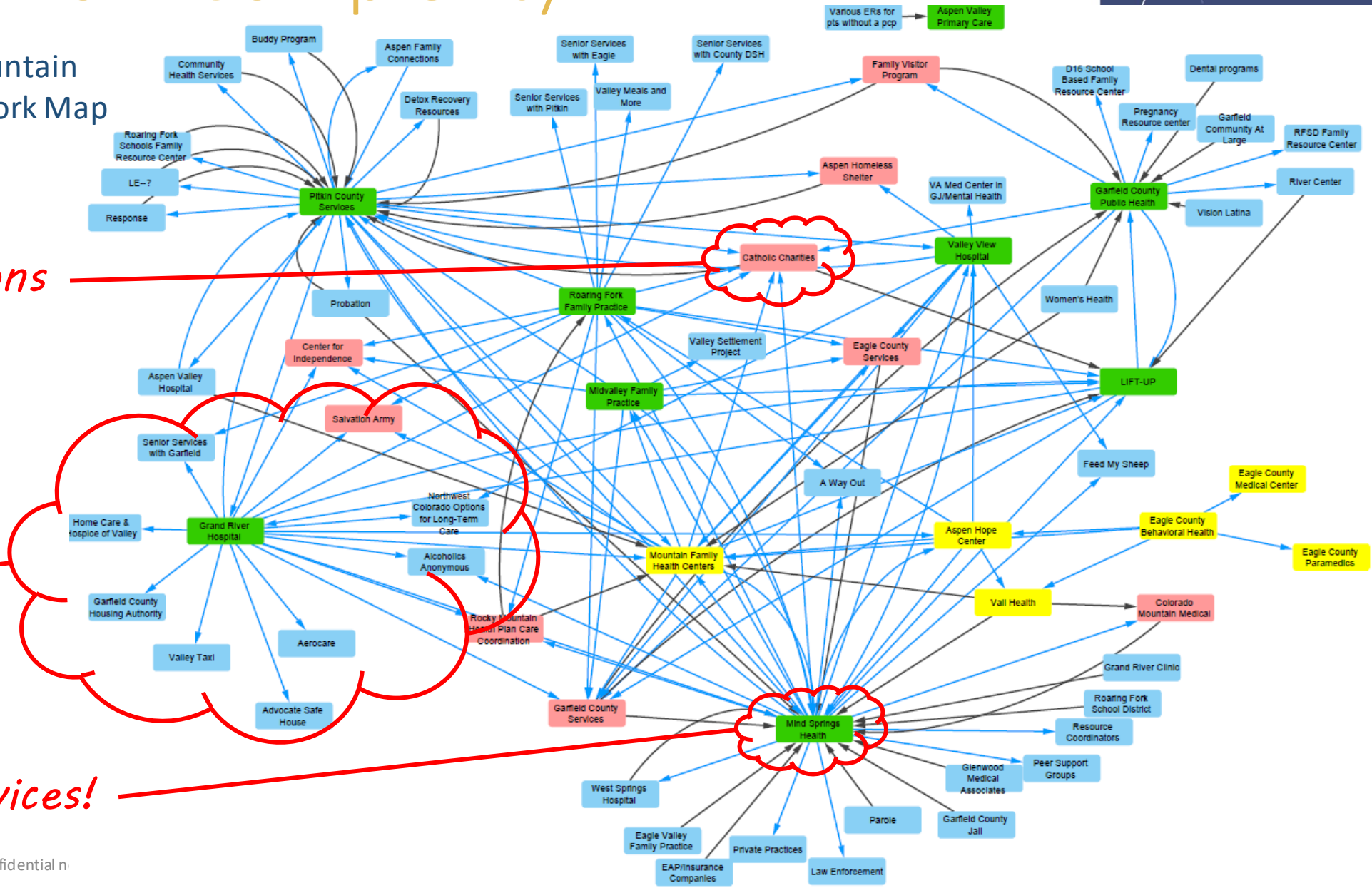
Partner and community readiness drives the conversation about where to start.

Community Lead Care Coordination



Partner Network Complexity

Pre-Implementation West Mountain Regional Health Alliance Network Map

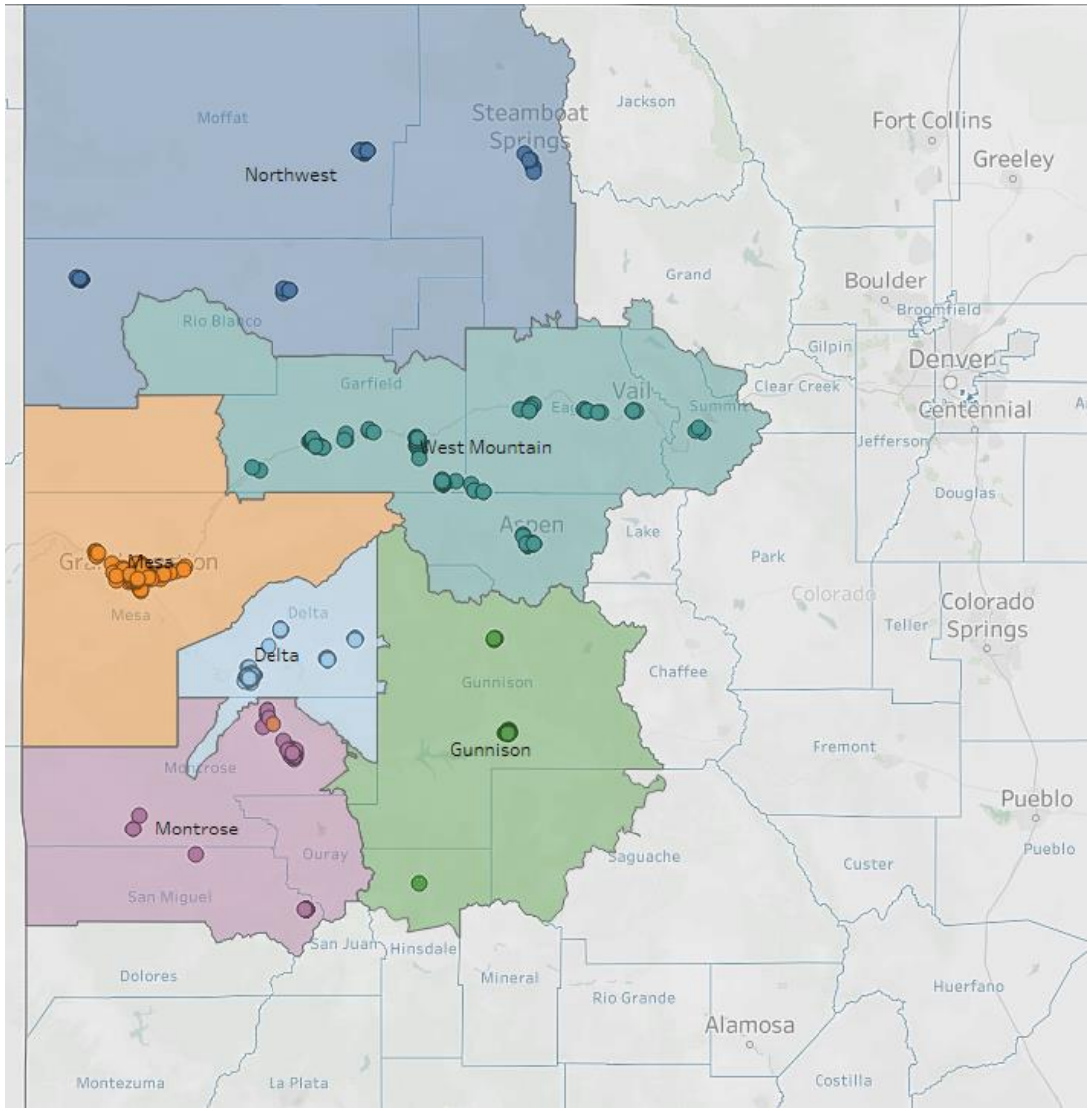


Bridge Organizations

Sub-Networks

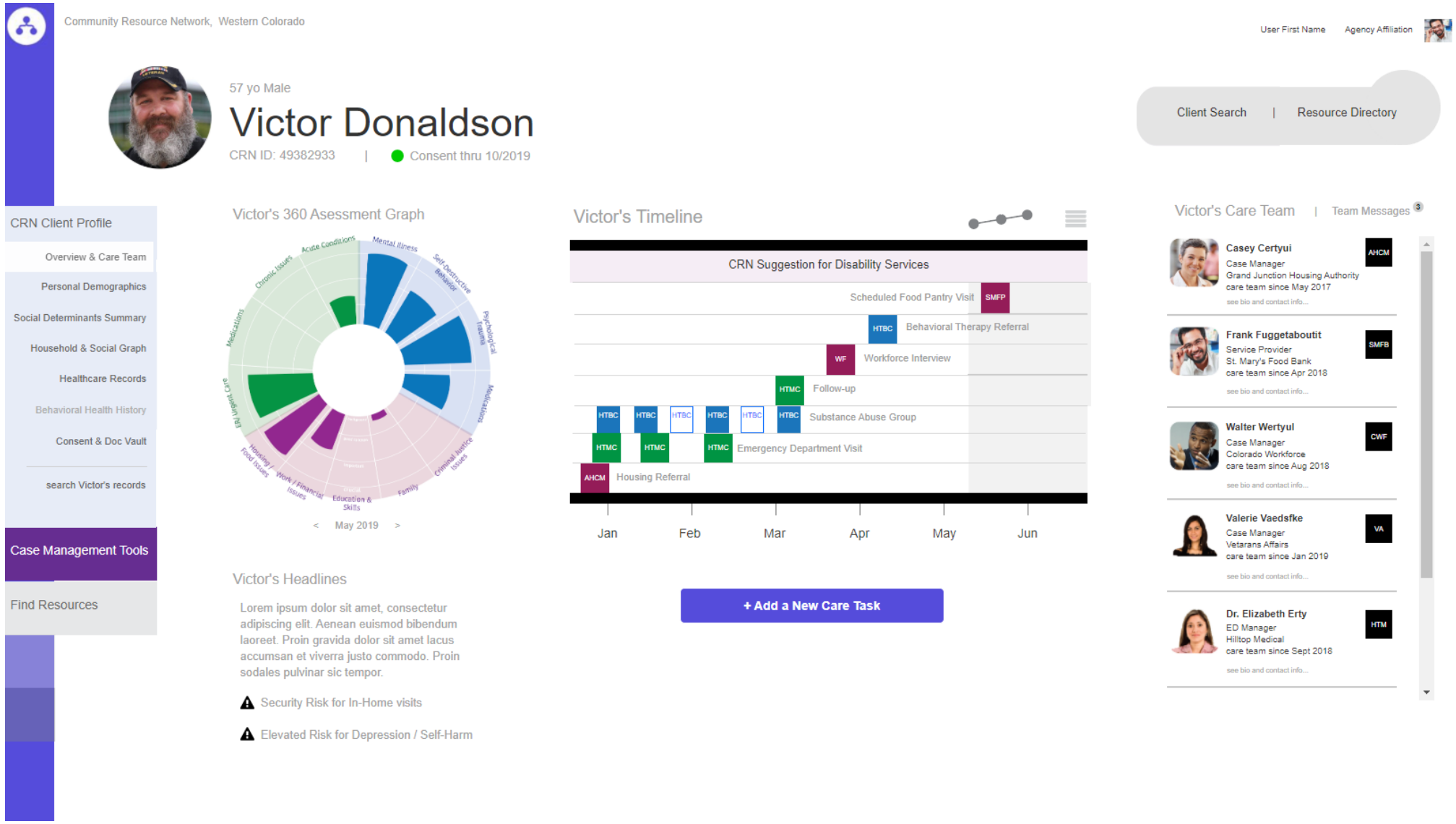
Essential Services!

Building Community Collaboration

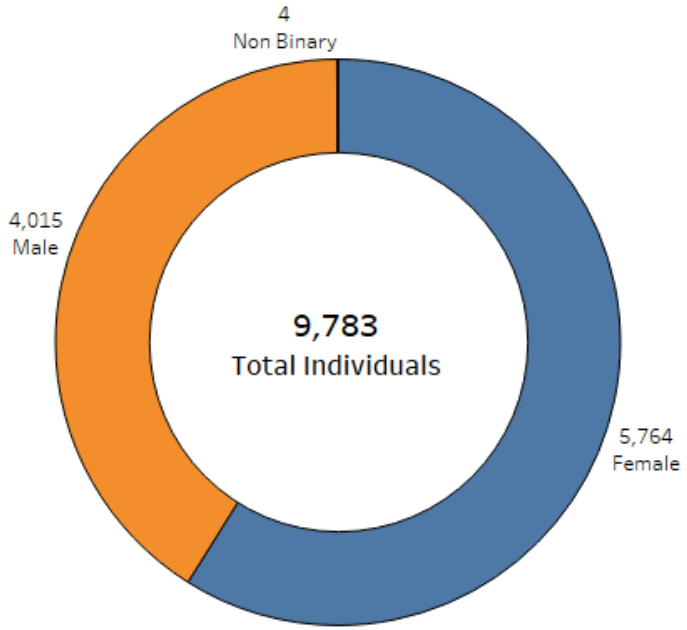


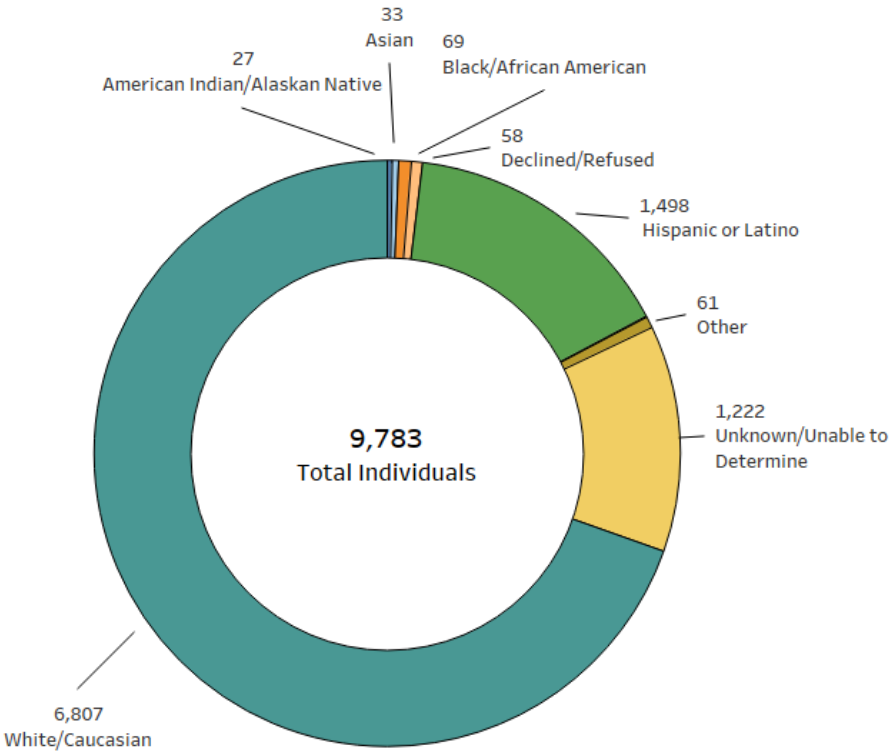
CRN Network	Partner Count
Mesa County Network	168
West Mountain	147
Delta County Network	76
Montrose Network	70
Northwest Network	34
Gunnison Network	14
Southwest Region	7

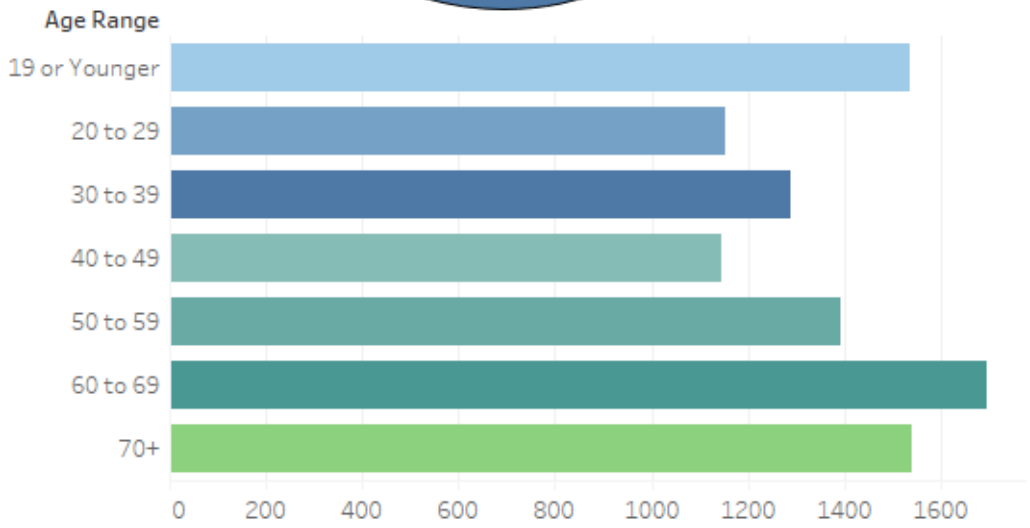
So, what is CRN?



Who are we helping?



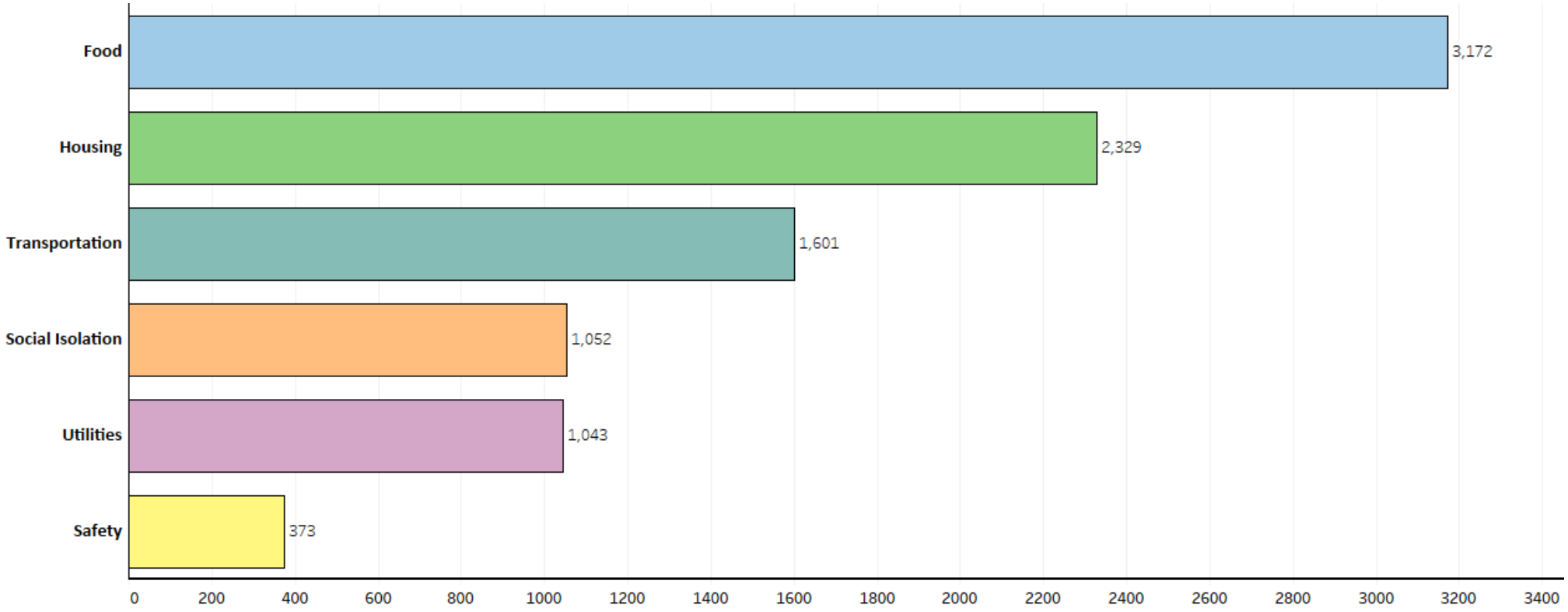




Race and Ethnicity	
American Indian/Alaskan Native	27
Asian	33
Black/African American	69
Declined/Refused	58
Hispanic or Latino	1,498
Native Hawaiian/Pacific Islander	8
Other	61
Unknown/Unable to Determine	1,222
White/Caucasian	6,807

What needs do they have?

- 6684 of 9783 screened (68%).
- 2,970 have been screened multiple times.
- 57% had an ER visit in the 12 months prior to screening
- 3043 (46%) with at least one identified need



What have we done so far?

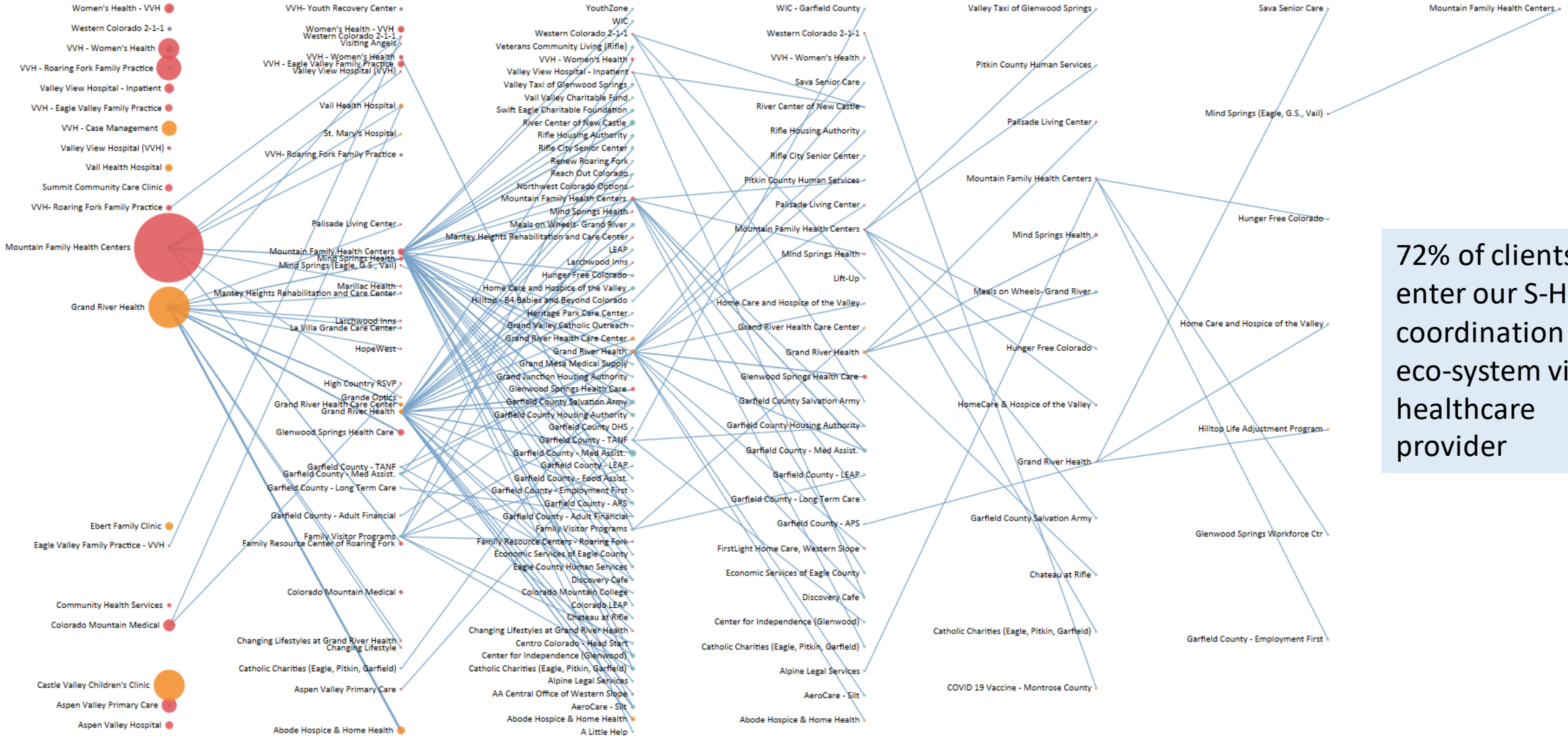
Over 3600 Referrals made to over 200 organizations/programs

**Large number of referrals made for Montrose-based COVID services*

Lesson #1:

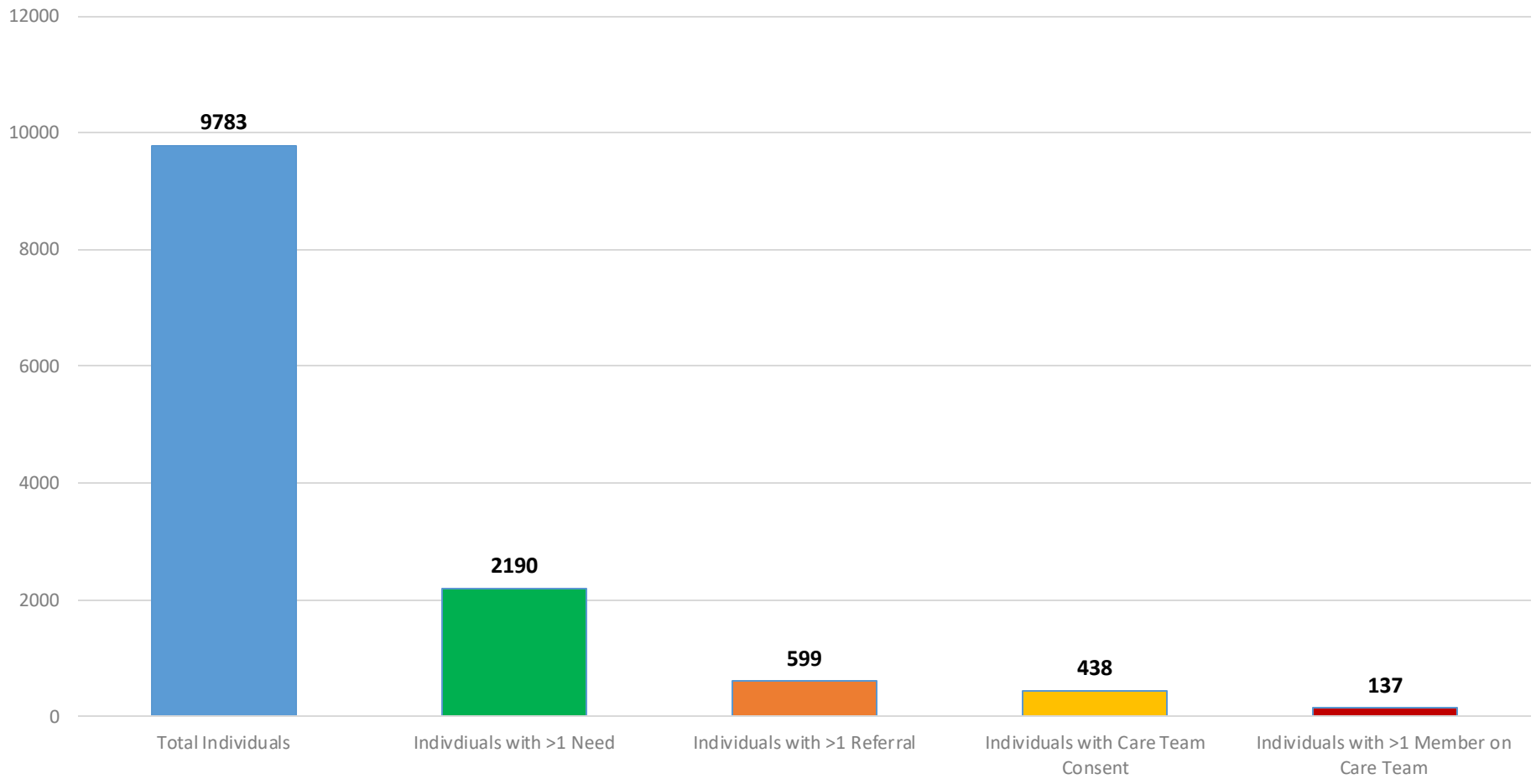
This level of collaboration does not happen organically, but Medical providers are integral to getting the ball rolling

Health Provider Initiated Referral Sequence: West Mountain Regional Health Alliance

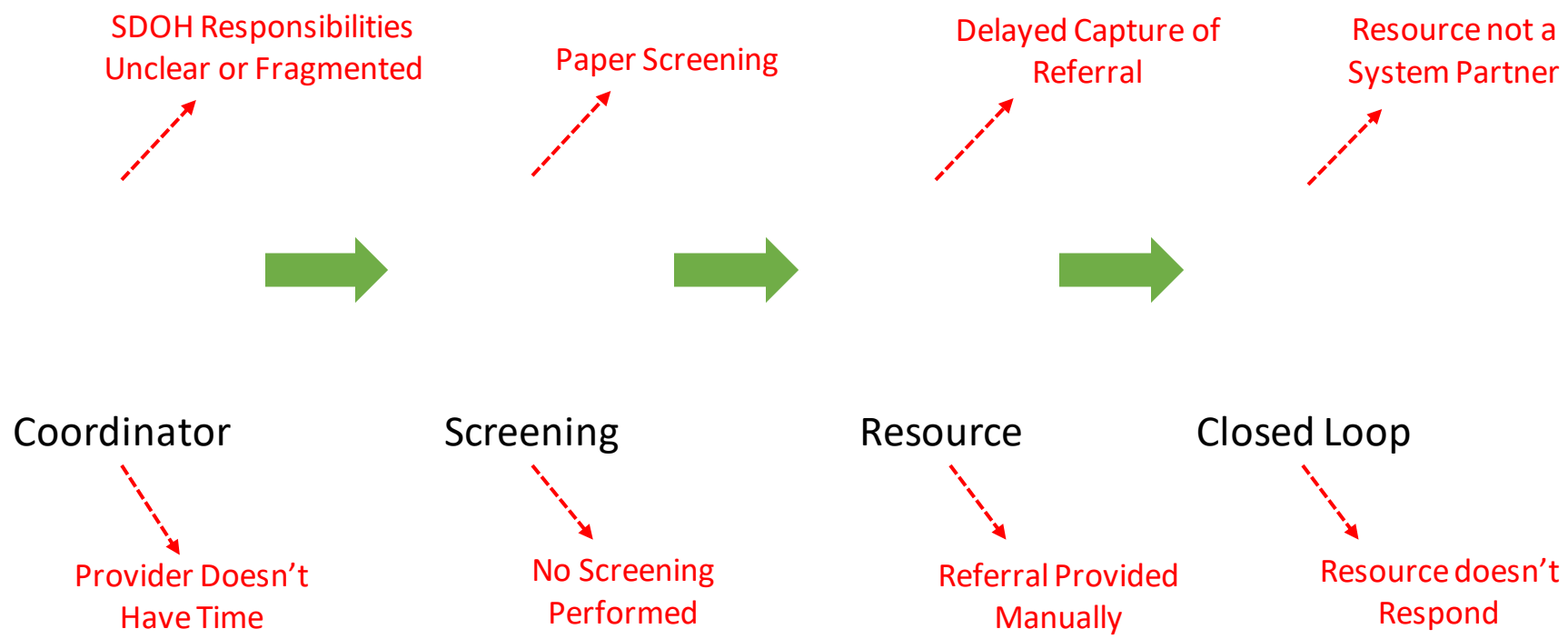


72% of clients enter our S-HIE coordination eco-system via a healthcare provider

Lesson #2:
“Coordination” beyond referral slow to develop



Lesson #3:
Changes to workflow take time

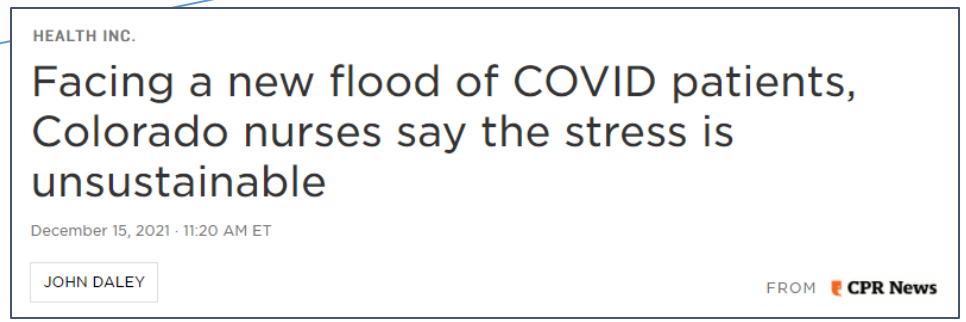


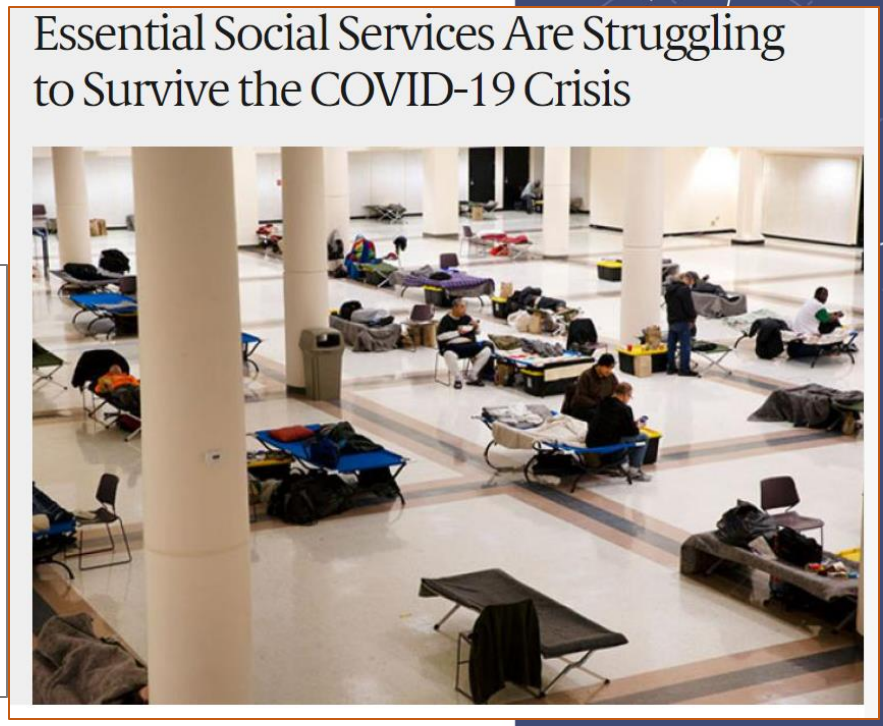
Lesson #4:
Demand for effective integration is extremely high

- Minimize Clicks
- Simplify Workflows
- Bi-Directional Data Flow
- EHR Integration Essential

Lesson #5:

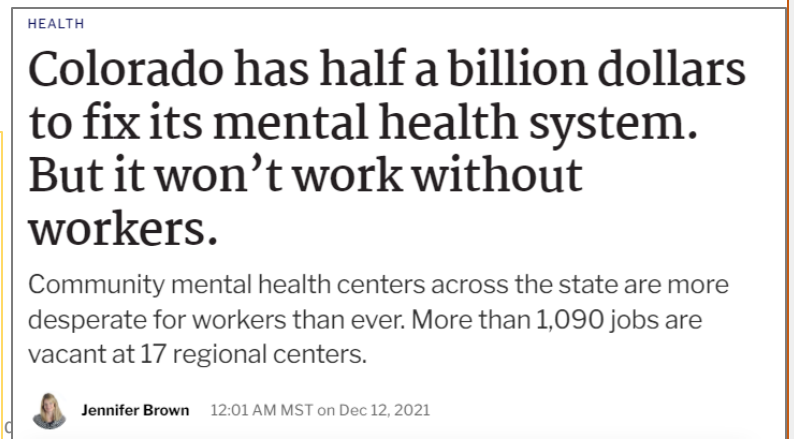
Need to be sensitive to pandemic pressures when implementing these changes





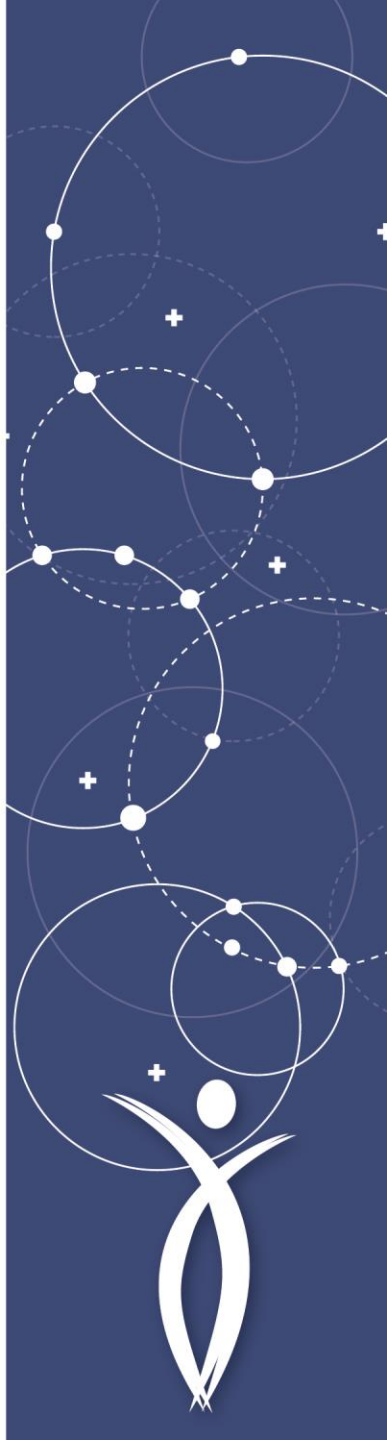
Covid Overload: U.S. Hospitals Are Running Out of Beds for Patients

As the coronavirus pandemic surges across the country, hospitals are facing a crisis-level shortage of beds and staff to provide adequate care for patients.



What's on the horizon?

- Alignment with "ready-made" care-coordination collaboratives
  - Behavioral Health
  - Opioid and Peer Recovery Coaching
  - School based housing projects
  - Built for Zero Coordinated Entry and Housing project
- Expand capabilities for bi-directional, transactional data sharing
- Continue to support community demonstration efforts and system expansion



Thank You!
Questions?

Jackie Sievers jsievers@qualityhealthnetwork.org
Jason McRoy jmcroy@qualityhealthnetwork.org

QHN

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PUBLIC COMMENT PERIOD

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CLOSING REMARKS