OeHI
Office of eHealth Innovation

Meeting Minutes

eHealth Commission

May 16th, 2018 | 12:00pm to 2:00pm | HCPF Conf Rm ABC

Type of Meeting	Monthly Commission Meeting
Facilitator	Co-Chair Jason Greer
Note Taker	Brendan Soane
Timekeeper	
Commission Attendees	Jason Greer, Mary Anne Leach, Chris Underwood, Morgan Honea, Justin Wheeler, Jon Gottsegen, Adam Brown, Dana Moore, Chris Wells, Marc Lassaux, Ann Boyer, Carrie Paykoc, Wes Williams

Minutes

Call to Order

- Jason Greer called the meeting to order as Co-Chair of the eHealth Commission

Approval of Minutes

- Attendance does not constitute quorum, so April minutes are not reviewed.
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Review of Agenda

-Jason Greer, Co-Chair

Announcements

OeHI Updates

a) OeHI Updates – Carrie Paykoc
   i) CHIMSS Advocacy Day – well-attended, good discussions on care coordination especially. Over 150 attendees. Next year will be the 10th anniversary.
   ii) Prime Health/OeHI Innovation Summit, May 10th. Great way to connect with innovators and entrepreneurs.
   iii) 10.10.10 – May 7 was the reveal of the 10 Wicked Problems and 10 CEOs. This year's focus is health, including many problems related to Roadmap initiatives. Mary Anne and I are validators, helping connect CEOs to resources and our own knowledge.

b) OeHI Updates – Mary Anne Leach
   i) Shout out to HCPF – big thanks to Chris Underwood and team.
   ii) Consumer strategy – funding proceeding. We are working on the IAPD. I met with Donna Lynne to get started on this effort. What this means is consumer literacy and consumer engagement. This is a good project to launch now.

SIM Updates

a) Ako Quammie – SIM
   i) SIM eCQM auto-extraction has kicked-off. Big project is onboarding 90 providers by the end of July. Issue around connectivity of EHR to HIE – EHR won't send data back to HIE. Been in contact with Governor's office. We want to ask EHRs not to put up barriers to eCQM efforts.

ii) Justin – how do practices enrolled in SIM know if their vendor communicates with HIE?
iii) Ako – we are working on that.
iv) Dana – maybe coming to C4 and asking CIOs to cosign that letter. I think they would cooperate.
v) Ako – We are working on defining what participation will include.
vi) Marc – SIM had HIE workday 2 months ago. We publish on our website which vendors we cooperate with and would be happy to add a column. Are we putting eHealth Commission behind this?
vii) Mary Anne – we could do that and for future efforts.

New Business

BoulderConnect – Paul Marola, CORHIO, Jason McRoy, Boulder County

a) Jason - In Boulder County, we have been working with a number of agencies for 12 years to attempt to improve social determinants of health. This is called the Integrated Services Model of Care. 5 steps: Enter through any door, receive the right services at the right time, connect to the community, EBP informed case management, increased stability and self-sufficiency. Technology would drive coordinated service delivery across Boulder services.
b) BoulderConnect is a community-wide, integrated case management and resource navigation platform. Capabilities: Integrated data from several state sources. Client consent and data access control. Workflow capabilities. Case management data view. Custom case management functionality. Client portal view. Partner portal view. Integrated service and referral marketplace for community resources – this allows partners and services in Boulder to actively populate their list of resources.
   i) Mary Anne – this is great to bring up – good to have a directory of patient resources. Do you have MPI?
   ii) Jason M – We have a proprietary algorithm – we hope with the partnership with CORHIO, we will have more capability in merging and matching.
c) We rolled out a coordinated single-entry process in Boulder county and have enrolled over 3000 who could potentially receive homeless services.
   i) Dana – how does this compare to last year?
   ii) Jason – we didn't know last year. There was a lot of manual matching.
d) To scale this out – we want a more sophisticated API, a better governance system. This is where we started working with CORHIO to scale this.
e) Paul – From native or third-party workflows, you can begin to find out what services are available. Hopefully we can start pulling from clinical domains, from EHRs
f) Jason – Need within Boulder County around certain programs – client utility is high and many are using resources. There is a lot of opportunity for scaling that.
g) Paul – the patient only has to share data once.
h) William – can you describe more of the third-party integration? What is the vision?
   i) Jason M – we have modeled the implementation for community partners who don't have a system that they are using. The bar for using is a bit lower. This model works for many community-based non-profits. For school systems, law enforcement, it is more difficult to integrate because they already have tools. So,

what are the core pieces of integration? Maybe sending a referral, sharing a case-plan, sharing an alert. This starts to identify what the use cases are for improvement.

i) Chris Underwood – 3rd Party connectivity is interesting to us in terms of Medicaid RAEs. The Boulder RAE mentioned that they are using BoulderConnect. So how can we get down to the data exchange? How is data currently exchanged and what is the vision?
   i) Jason – There are organizations that are connected – one version is from an organization side, and also a client advocacy side, where there is low risk and not as much data is exchanged. There is an intent to understand how to serve high-risk people better. We have high-level data exchange. We want to understand and identify what the right interventions are for individuals, so they can be properly matched to services.
   ii) Paul – We want to give insight to RAEs as to what community services are available. We will be working with CRISPeR program to identify whether individuals have received their services. This is happening right now. We need to align advanced-care planning domain. Death and dying is an important place to look at.

j) Dana – how is this funded?
   i) The county had some supplemental dollars to get things going. We started with local dollars, used local innovation grants from HCPF. County is maintaining the application now, so the only cost is the Salesforce license. Previously we were using a cost-management solution that didn't connect everything we needed it to.
   ii) Morgan – Good question – this is important in terms of scaling.
   iii) Dana – how do you leverage what Boulder has done across the state?
   iv) Mary Anne – some of our Roadmap money could go to fund this. As EHR vendors start to incorporate social determinants data so it is in EHR workflow.
      (1) Paul – we need to make sure with vendors that we are using use the same categories of information.
   v) Morgan – As this request becomes more prolific – 64 counties with many agencies requesting this information, how can we consolidate interfaces from both side of the equation?
   vi) Kim Bimestefer – on expanding around the state – what conversations have you had with carriers?
      (1) Paul – we have not begun those conversations.
      (2) Kim – I would suggest you do. They are interested in expanding this across the state. Please send me some verbiage around your slides and what you are doing.
   vii) Jason – We signed a contract with migrating database to CORHIOs database hosting requirement. This will be helpful for expansion. As I mentioned, we need to develop with an eye towards expansion. There is an opportunity to widen the scope of the care team. We want to start picking off use cases to demonstrate the efficacy and the immediate value. As a concrete next step, we are looking for guidance and insight to sanction this partnership. We don't have a great plan yet on how to grow this out. What is the right process? We are open to input, questions and feedback.
   viii) Chris Underwood – we need to consider that we don't have data use agreements with any counties – could we come up with a framework to automate the creation of data use agreements? At the end of the day, we are working with

RCCO partners to do integration with that. The client may not be willing to give consent for all things. Could we think about the consent framework so we can coordinate without checking every box?
(1) Justin – this is more important with delegated practices.

ix) Morgan – Aligning API strategies with OIT – these things can be converged into a single vision and shared vision. Once the infrastructure is laid, you can invite innovation in. It's easier to plug in to an ecosystem that already exists.

x) Chris Underwood – what excites me is a connection to a provider directory. If we can think about how to integrate the Master Provider Directory so we integrate only once, that would be helpful.
(1) Marc – integrating the provider directory is low-hanging fruit. We are combining data from the social side with data from the health side.
(2) Morgan – a good example of that is what QHN did with advance directives. QHN did a pilot program so advanced directives were available within the HIE.

xi) Justin – social determinants of health is the next wave of implementation. People don't always want to get a positive response because it puts a burden on them. They really need to know the next step. With CRISPeR, for instance, you remove all of those barriers. What you are building is a trusted infrastructure. These are catalysts for people doing social determinants of health screenings. On RAE, total cost of care, is there a potential overlap between PEND, EDT information?

xii) Morgan – there are many things you can do with real-time notification ability.

xiii) Justin – one social service could intervene at another service.

k) Dana – We will need to figure out how to measure outcomes. Unless we can say how we make a difference – how are we going to show improvement?

Provider Directory
Steve Holloway- CDPHE

a) If you are interested more in the architecture, talk to me individually. I would be happy to talk to you.
b) We exist in statute to address issues in primary care from a population perspective. These include assessing communities for primary care, oral care and mental health care, researching and developing policy to improve access, and promoting and administering health professional practice incentive programs. You can't assess need without reliable denominator data. The office itself has been around for around 40 years – we've passed certain questions inside licensure process to ensure needs assessment. The core use case that we have is challenge for many of our partner organizations.
c) Most of our work has taken place over the last four years. The goal was to try and identify solutions that partners would benefit from. July 2017 – five year implementation development and hosting completed. First true gold record, produced at the end of 2017. Gold record is best possible estimate of provider place and plan.
d) We want to know exactly what providers are doing including hours of business.
e) We use a variety of data sources – but the data decay rate is fast – 2.5 percent change every month in provider directory. The value of having multiple data sets is

important so we can update it frequently. We have feeds from CMS, DORA, CIVHS, HCPF and CDPHE. We often find that doctors not taking patients are still on our list.

f) As PCO (Primary Care Office), we often use surveys to gather information. We have a universal template which is a good way to introduce ad hoc information. We are currently developing a user interface. We dynamically score each field related to each provider to validate their information. We can also filter and query the data in the system. These data include date, boarding, profession, training, geography, payer, and demographics. Denominator is all providers including physicians, dentists, social workers. All who are licensed.
g) One thing we are interested in is the age of physicians – we can look at the percentage of physicians that are over 60 so we can predict physician resources.
h) There are 147,000 clinicians in Colorado. We want to match clinicians with populations they serve. There is a wide variety of data analysis we can do.
i) Chris U – how do you link a physician with the site?
    i) Steve – we have a lot of different sources so it's easier for us to do that.
    ii) Steve – value – practices can compare clinician data.
j) Currently in development – We are finalizing the user interface and first release to data partners, continuing reports development – standardizing reports release to data partners, additional importing, algorithm and quality testing. We are planning on bringing in 2 million rows per month. We also need to code for additional sources.
k) Planning – data cleaning and standardization, soundex for alpha matching data, API, public directory search, geographic claims analysis.
l) We can analyze travel times, where people get care, care intensity (visits per resident).
m) With APCD data, we hope to look at demographic information – we can relay information in a couple of different directions.
n) Mary Anne – this looks great. Can providers update their own information?
    i) Steve – this is definitely something we have thought about.
    ii) Mary Anne – how accurate is the data?
    iii) Steve – right now the data looks really good, but it's hard to know without a better data source.
    iv) Tamara, CDPHE – we've halved the error rate with each iteration – maybe down to 6% now.
o) Justin – what is the strategy around home addresses for providers?
    i) Steve – we gather home addresses around the license, but we are figuring out the exact data. We don't want to release home addresses, even though it is potentially available online. We will work with stakeholders to release the correct data.
p) Justin – provider retention info and salary info are interesting to me surrounding recruitment and retention of primary care providers. Do you anticipate response from others who occupy markets regarding salary data?
    i) Steve – we realize we might move into people's business models, but it is not something we have found commercially. We really want to provide this information cheaply and to people who need it.

Colorado Health IT Roadmap Initiatives
Mary Anne Leach, OeHI

1) Care Coordination Initiative WG – Mary Anne Leach
   a) Please look at materials afterwards, let Mary Anne know whether we have missed a key stakeholder group.
2) HIE & Data Sharing Initiative WG – Mary Anne Leach
   a) Look through this as well to make sure we have all stakeholders.
   b) Both of these workgroups should come back with advice for funding.
   c) Morgan – do you envision this workgroup discussing not only health data?
      i) Mary Anne – potentially. We do have funding for a statewide architect.
   d) Mary Anne – at some point we will have several product managers.

Public Comment

1) Public Comments – none.
2) Closing Remarks – none.
3) Action items – minutes for next month, approving workgroups. Meeting adjourned.