



Steering Committee

REMINDER: please print your own hard copies of meeting materials

Meeting Date: Wednesday, October 8, 2008
Time: 2:00 pm to 4:00 pm
Location: 931 Spring Street, Conference Room
Dial in number: 888-566-8440, passcode 228780#

Committee Members: Greg Bergner, MD, John Bachman PhD, Dick Derby, Jim Ellsworth, Neda West, Jon Lehrman MD, Shannon Truesdell MPA RN,

Invited Guests: Maria Chaves, Sandra Dunn, Dana Davies, Rob Quadri, Peggy O'Brien, Neda West

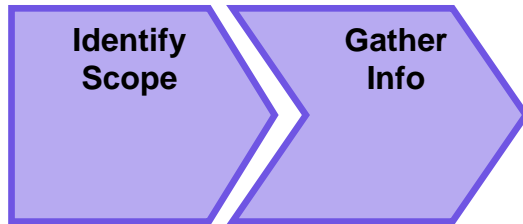
| <u>Time</u> | <u>Topic</u> | <u>Outcome</u> | <u>reference</u> |
|-------------|---|--|------------------|
| 2:00 | 1. Welcome, Introductions and Agenda Review | | |
| 2:05 | 2. Changes or additions to minutes from August 20, 2008 | Decision: approve, modify or reject | pages 2 - 4 |
| 2:10 | 3. Multi year amended IT plan <ul style="list-style-type: none"> Alignment of agency priorities each participant identifies their agency's top 3 priorities | Identify potential conflicts and synergies with ACCEL's 2009 work plan | Pages 5 - 7 |
| 2:40 | 4. ACCEL workplan, participant resource allocation, and schedule of meetings | Decision: approve, modify or reject proposed workplan | Pages 8 - 11 |
| 3:10 | 5. SPHERE update <ul style="list-style-type: none"> ED utilization analysis Methodology to measure ACCEL participant revenue modeling | Decision: approve, modify or reject proposed methodology | Pages 12 - 14 |
| 3:30 | 6. Care Pathways QA Plan | Decision: approve, modify or reject proposed QA plan | Pages 15 - 17 |
| 3:45 | 7. Staff Updates <ul style="list-style-type: none"> BSCF application update | Status of requests, funding, and gaps | Meeting handout |
| 4:00 | 8. Closing | Agenda items for next meeting, November 12 | |

Next meeting: October 8, 2008, 2-4 pm

ACCEL's HIE Technology Plan

A structured process was followed to clarify goals and strategies and to recommend objectives

What objectives do we want to achieve?



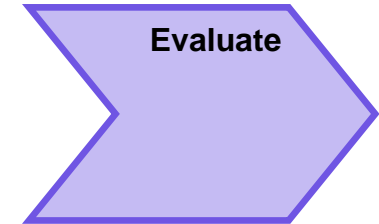
- Strategy Focus
- Scope
- Assumptions
- Decision areas
- Nat/State policy environment
- Review techn. project phases
- Assumptions
- Workgroup recommendations
- Techn. advances & uncertainties
- What we learned to date

How will we get there?



- Options
- Pros/cons
- Risks
- Prioritize alternatives
- Range of returns
- Key risk factors & mitigation
- 3-year plan
- Annual business plan
- Budget
- Communication

How will we know success?



- Outcomes to measure
- Metrics

ACCEL HIE implementation plan has been revised to address updated information regarding pacing and funding

NOTE: Each phase relies on external grant subsidies, a commitment from participating organizations to resource committees and deployment of governance best practices

2004 - 2006

2007

2008

2009

2010

| Phase 1 Organization | Phase 2 Mobilization | Phase 3 Automation | Phase 4 Automation /Evaluation | Phase 5 Actualization |
|---|--|--|--|--|
| <ul style="list-style-type: none"> • Investigate interests, potential benefits, level of commitment • Engage and align organizations • Prepare overall project plan • Establish and kick off project teams • Test processes & programs on a paper or fax basis | <ul style="list-style-type: none"> • Establish governance committee • Develop HIE business case • Determine governance success metrics • Initiate workgroups • Determine future funding and revenue plan • Determine overall ACCEL project functionality/phasing plan • Develop common consent agreement • Initiate implementation of Care Pathways software | <ul style="list-style-type: none"> • Develop HIE implementation plan • Care Pathways Go-Live • EMPI Go-Live • Secure implementation resources (multi-year) • Revise phasing plan as necessary • Monitor programs & establish quality improvement targets • Preliminary evaluation of Care Pathways • Specialty Care Plan | <ul style="list-style-type: none"> • Adopt and execute on business plan • Pilot data exchange to include clinical info • Evaluate impact of increased automation on administrative efficiency • Provide comprehensive facilitation and training for the new practices • Establish resources for ongoing maintenance • Develop and execute stakeholder engagement & communication plan • Revise governance as needed | <ul style="list-style-type: none"> • Establish continuous improvement infrastructure • Determine future phase plans • Expand data exchange to include more data points and/or more sites • Connect to CalRHIO • Evaluate impact of ACCEL overall & specific clinical outcomes • Publish findings of ACCEL programs |

HIE Objectives

Implement pilot in SLT between Barton & County Department of Public Health

Objective #1:

By March 2009 the ACCEL Steering Committee reviews and approves HIE vendor selection for contracting

Objective #2:

By August 2009 adopt and execute a strategic business plan that addresses long term sustainability of the ACCEL HIE

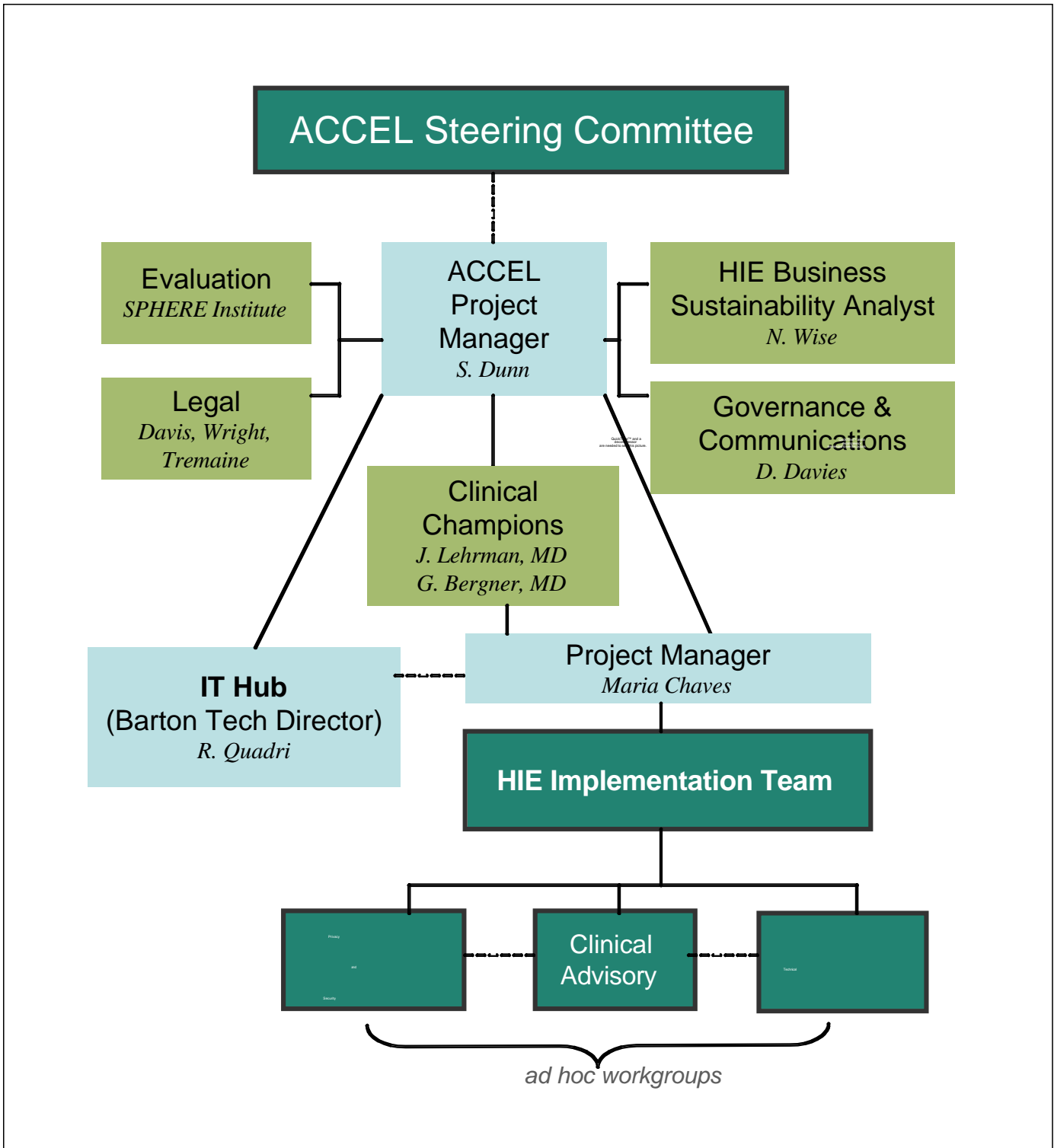
Objective #3:

By December 2009 implement the HIE pilot linking Barton Healthcare System with El Dorado County Department of Public Health

| ACCEL Health Information Exchange Implementation -- Project Timeline | | | | | | | | | | | | | key milestone | | |
|--|------|-----|-----|------|-----|-----|-----|-----|-----|-----|-----|-----|---------------|-----|-----|
| | 2008 | | | 2009 | | | | | | | | | | | |
| | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC |
| Update business sustainability planning | | | | | | | | | | | | | | | |
| Prioritize project goals & objectives for project phasing | | | | | | | | | | | | | | | |
| Update/clarify HIE goals , outcomes and monitoring | | | | | | | | | | | | | | | |
| Recommend project phasing | | | | | | | | | | | | | | | |
| Determine financial impact of HIE structure & functionality | | | | | | | | | | | | | | | |
| Recruit health plan, employer and community advisors for input | | | | | | | | | | | | | | | |
| Develop and adopt revenue & funding plan | | | | | | | | | | | | | | | |
| Initiate performance monitoring | | | | | | | | | | | | | | | |
| Update HIE analysis and select data model architecture | | | | | | | | | | | | | | | |
| Review technical systems, standards & reqt's for implementation | | | | | | | | | | | | | | | |
| Refine clinical data set using new goals, objs & project phasing | | | | | | | | | | | | | | | |
| Steering Committee review & approval of HIE data sharing model | | | | | | | | | | | | | | | |
| Procure HIE vendor | | | | | | | | | | | | | | | |
| Start 1st demos for short list of vendors based on prior HIE work | | | | | | | | | | | | | | | |
| Prepare requirements/specifications & validate w/ stakeholders | | | | | | | | | | | | | | | |
| Prepare and distribute RFP, develop selection criteria and tools | | | | | | | | | | | | | | | |
| Conduct HIE vendor examination and finalist selection | | | | | | | | | | | | | | | |
| Steering Committee approval of vendor recommendation | | | | | | | | | | | | | | | |
| Initiate and finalize vendor agreement | | | | | | | | | | | | | | | |
| Implementation: Phase 1 | | | | | | | | | | | | | | | |
| Formalize the project plan | | | | | | | | | | | | | | | |
| Communication and change management | | | | | | | | | | | | | | | |
| Define / commit and put into place allocated resources | | | | | | | | | | | | | | | |
| Finish workflow redesign: navigation, data elements, operations | | | | | | | | | | | | | | | |
| Prepare operations plan: security, privacy, clinical support | | | | | | | | | | | | | | | |
| Develop & finalize detailed requirements/functional specifications | | | | | | | | | | | | | | | |
| Install HIE vendor hardware & software | | | | | | | | | | | | | | | |
| IT development for all stakeholder systems | | | | | | | | | | | | | | | |
| Develop testing plan | | | | | | | | | | | | | | | |
| Hardware and software testing: all systems | | | | | | | | | | | | | | | |
| Develop training plan, materials, and execute | | | | | | | | | | | | | | | |
| Go live | | | | | | | | | | | | | | | |

key milestone

ACCEL HIE Project Staffing



Staff positions

Consultants

Chartered work teams

ACCEL Project Workgroups

Steering Committee

**Commitment:
Monthly 2008 -2009**

| | |
|-------------------------|---|
| Sandra Dunn | ACCEL Program Manager |
| Nancy Wise, Dana Davies | ACCEL Consultants |
| John Bachman, Ph.D | Director EDC Mental Health Dept |
| Greg Bergner, MD | ACCEL Physician Champion – So. Lake Tahoe |
| Jon Lehrman, MD | ACCEL Physician Champion – Western Slope |
| Dick Derby | CFO Barton HealthCare System |
| Jim Ellsworth | CEO, EDC Community Health Center (FOHC) |
| Shannon Truesdell | COO, Marshall Medical |
| Neda West | Acting Director, EDC Public Health Dept. |

HIE Implementation Team

**Commitment:
Feb – Dec 2009**

| | |
|---|--|
| Sandra Dunn | ACCEL Program Manager |
| Maria Chaves | ACCEL HIE Project Manager |
| Greg Bergner, MD <i>in recruitment</i> | ACCEL Physician Champion – So. Lake Tahoe Barton HIE IT Project Manager |
| Sharon Elliott | Division Mgr, EDC Dept of Public Health |
| Carole Melzer | Barton Hospital Supervisor |
| Sharon Bishop | Barton Community Clinic Manager |

Clinical Advisory Work Group

**Commitment:
Oct - Nov 2008 & Nov - Dec 2009**

| | |
|---------------------------|--|
| Sandra Dunn, Maria Chaves | ACCEL Program & HIE Project Managers (staff) |
| Jon Lehrman, MD | ACCEL Physician Champion – Western Slope |
| Greg Bergner, MD | ACCEL Physician Champion – So. Lake Tahoe |
| John Versoza, MD | Medical Director, HIS Tribal Clinic |
| Clint Purvance | Barton Health System CMO |
| Jason Eberharrt-Phillips | EDC PHD Medical Officer |
| TBD | EDC Mental Health Dept rep |
| Amy Haase, MD | Barton Hospitalist |

Privacy & Security Work Group

**Commitment:
May – Aug 2008**

| | |
|----------------|---|
| Sandra Dunn | ACCEL Program Manager (staff) |
| Kim Wells-Ball | Barton Privacy Officer |
| Janet Parnell | EDC Privacy Office |
| Gloria McNeill | Marshall Privacy Officer |
| Sharon Bishop | Practice Manager, Barton (rural) clinic |
| Sharon Elliott | Division Mgr, EDC Public Health Dept. |
| Greg Bergner | SLT Physician Champion |
| Lesley Gomes | EDC Legal Counsel |

Technical Work Group

**Commitment:
Mar – Nov 2009**

| | |
|-----------------------|----------------------------------|
| Maria Chaves | ACCEL HIE PM (staff) |
| Rob Quadri | Barton IT Director |
| <i>in recruitment</i> | Barton HIE IT PM |
| Tom Simpson | EDC IT Analyst |
| Robert Floresguerra | Marshall IT PM |
| Trever Lee | ACCEL IT Analyst (Care Pathways) |

| Aug - Dec When | TBD Topics | Desired Outcomes |
|----------------------|---|--|
| Nov 2008 | <ul style="list-style-type: none"> • Discuss HIE goals & objective • Campaign - ACCEL HIE funds/revenue recommendations • Report - clinical & technical HIE definition, project phasing • Present EMPI | <ul style="list-style-type: none"> • Refined draft of HIE goals & obj • Agree on interim fund program & assignment • Decision on EMPI value • Program course correction, if needed |
| Dec 2008 | <ul style="list-style-type: none"> • HIE goals & objectives • Clinical & technical HIE recommendations • Vendor short list & procurement process review • Interim fund program status • Specialty care proposal (CHCF) | <ul style="list-style-type: none"> • Approval of HIE goals & objs. • Approval of clinical data & phasing • Approval of technical architecture, standards • Approval of HIE procurement process, selection criteria • Continued commitment for interim fund work |
| Jan 2009 | <ul style="list-style-type: none"> • Business plan introduction • HIE RFP status report • Other stakeholder recruitment as business plan advisory resource • Interim fund program status • Care Pathways update | <ul style="list-style-type: none"> • Commit to business plan assignments • Commit to recruit other stakeholders for bs plan input • Continued interim fund work |
| Feb 2009 | <ul style="list-style-type: none"> • HIE vendor selection • Business plan work • Interim fund update | <ul style="list-style-type: none"> • Approval of HIE vendor recommendation • Commit to business plan assignments • Continued interim fund work |
| March 2009 | <ul style="list-style-type: none"> • HIE vendor contract report • HIE implementation work plan • Business plan work refinement • Interim fund update | <ul style="list-style-type: none"> • Approve HIE technical contract • Approve work plan • Commit to business plan assignments • Continue interim fund work |
| April 2009 | <ul style="list-style-type: none"> • HIE work update • Business plan work refinement • Partner agreement in light of HIE | <ul style="list-style-type: none"> • Continued support for business plan assignments • Commit to in-house legal review of draft HIE agreement |
| May20 09 | <ul style="list-style-type: none"> • Draft business plan for review • HIE pilot check in • Outstanding partner agreement issues | <ul style="list-style-type: none"> • Business plan ready for final • HIE course correction, if needed • Resolution of partner agreement issues |
| June 2009 | <ul style="list-style-type: none"> • HIE pilot check in • Business plan document • Draft partner agreement | <ul style="list-style-type: none"> • HIE course correction as needed • Business plan adopted & commitment to execute terms • Resolution of partner agreement issues for final document |
| July 2009 | <ul style="list-style-type: none"> • HIE pilot check in • Partner agreement ready for signatures • Business plan execution activities • ACCEL policies & procedures draft updates in light of HIE | <ul style="list-style-type: none"> • HIE course correction as needed • Partner agreement signatures obtained • Business plan execution on target • Approval of policy & procedure recommendations |

**Project Access for El Dorado County (ACCEL)
Key Findings on the OMH Pathway for the Steering Committee
October 2008**

Introduction

The Obtaining a Medical Home Care (OMH) Pathway was implemented on the western slope in August 2006. As children without a primary care provider seek treatment in the emergency department (ED), they and their siblings are referred to a Community Health Worker who connects them with a primary care provider that will serve as a medical home. A case is closed successfully when the child attends two appointments at his/her new provider site.

- Overall, progress on this pathway has been steady over the years, with the majority of clients successfully completing the OMH Pathway (Table 1).

Table 1: OMH Pathway Completion Rate (as of June 30, 2008)

| | Year One* | Year Two | Year Three | Total |
|---|-------------|-------------|-------------|------------|
| Total Cases Opened (Monthly Average) | 13 (6.5) | 158 (13) | 123 (14) | 294 |
| Appointment Kept | 100% | 82% | 81% | 83% |
| Appointment Not Kept | 0% | 17% | 12% | 14% |
| Cases Pending | 0% | 1% | 7% | 3% |

* Pathway initiated in August 2006; therefore it only operated during two months of Year One.

- Providers have been particularly supportive within the OMH Pathway; over two dozen providers have agreed to accept one publically insured client referred from this pathway a month (Table 2). The El Dorado County Community Health Center and the Marshall Center for Primary Care take a large share of all clients.

Table 2: Percent of Clients Referred to Each Provider

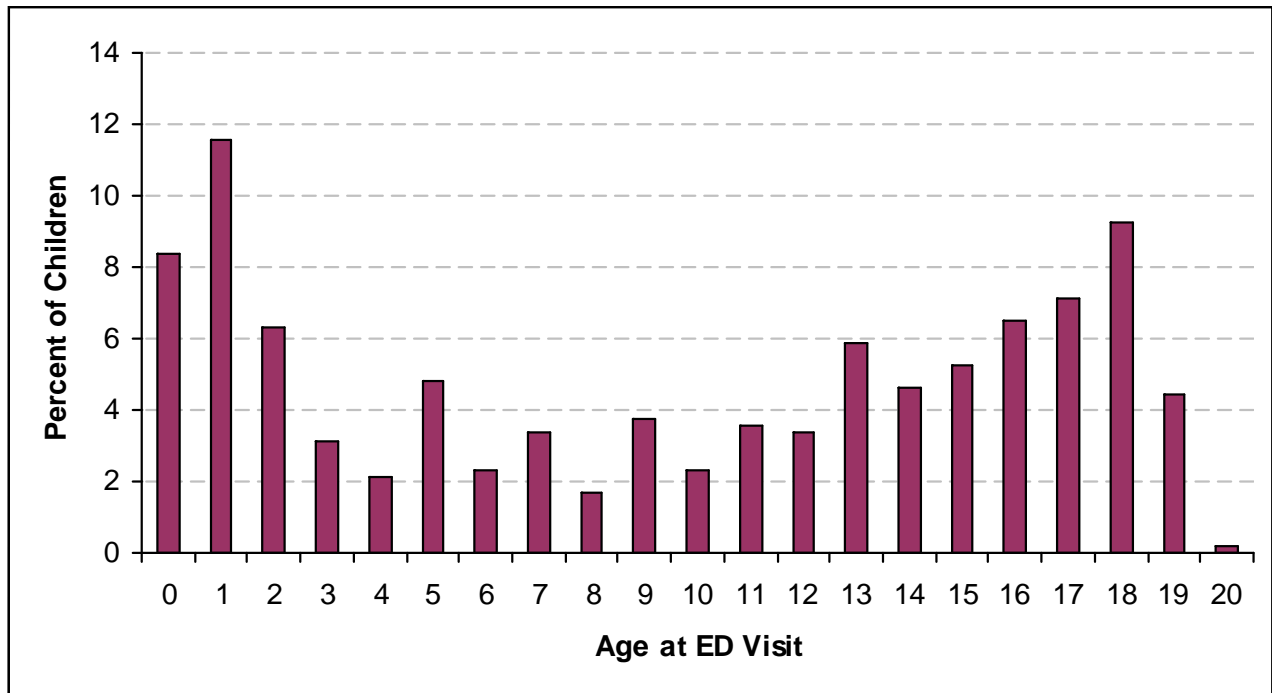
| Provider Site | Year Two | Year Three |
|---|------------|------------|
| El Dorado County Community Health Center | 51% | 48% |
| Marshall Center for Primary Care | 29% | 30% |
| Placerville | 18% | 18% |
| Cameron Park | 7% | 8% |
| Pediatrics | 3% | 3% |
| El Dorado Hills | 1% | 0% |
| Divide Wellness Center | 8% | 4% |
| Kaiser | 1% | 9% |
| Tribal Health | 5% | 3% |
| Private Practice Providers (4) | 3% | 5% |
| Referred out of County | 3% | 0% |
| Cameron Park Pediatrics | 0% | 2% |

Through the OMH Pathway, children are more frequently connected to a primary care provider, thereby improving health outcomes and reducing the frequency of ED visits and health care costs. Our methods for measuring the impact of OMH Pathway enrollment on ED visit patterns and findings are summarized below.

Methods

- **Study Population:** The study population included 141 children who enrolled in the OMH Pathway between September 1, 2006 and June 28, 2007 as a result of visiting the Marshal Medical ED, a sibling’s ED visit, or participation in another pathway.
- **Before and After Analysis:** We compared the ED visit patterns of children twelve months *before* they entered the OMH Pathway to their ED visit patterns twelve months *after* they entered the pathway.
 - This before and after method had an inherent control for characteristics that could have influenced ED visits—such as gender, ethnicity, socioeconomic status, and chronic disease—that are held relatively constant over a child’s life.
 - In contrast, this before and after method does not control for age, which changes over time. We found that ages 0, 1 and 18 are most “dangerous”—that is, children of these ages are most likely to visit the ER than others (Figure 1). However, age does not affect our analysis because children in the before and after groups were likely to move in and out of “dangerous” ages at the same rate.

Figure 1: Percent of ED Visits by Age at Visit



- **Outcome Measures:**
 - Average number of ED visits before and after enrollment.

- Percent of children who were high-frequency ED users (defined as having three or more ED visits) and moderate-frequency ED users (defined as having two ED visits) before and after enrollment.

Results

- **Average Number of ED Visits:** The average number of visits decreased by 0.6 visits (Table 3). The maximum number of visits by a single child also decreased from 7 visits in the before period to 6 visits in the after period.

Table 3: Average Number of ED Visits

| | 12 Months Before Pathway Enrollment | 12 Months After Pathway Enrollment |
|----------------|--|---|
| Average | 1.5 | 0.9 |

- **Percent of Frequent ED Users:** Children were less likely to be high and moderate-frequency ED users after enrollment (Table 4)
 - Of the 49 moderate to high frequency users before program enrollment, only 18 remained moderate to high frequency users after program enrollment.

Table 4: Percent of Total Number of Children by Frequency of ED Visit Status

| | 12 Months Before Pathway Enrollment | 12 Months After Pathway Enrollment |
|---------------------------|--|---|
| Moderate-frequency | 31 (13.0%) | 14 (5.9%) |
| High-frequency | 18 (7.5%) | 12 (5.0%) |

- **These data suggest that the OMH Pathway reduces children’s ED use.** The average and maximum number of ED visits per child as well as the number of moderate- and high-frequency ED users were lower during the 12 months after pathway enrollment compared to the 12 months before pathway enrollment. Following program enrollment, there was an approximate 64% reduction in the number of moderate- and high-frequency ED users.

ACCEL Care Pathways: Proposed Quality Assurance Program Approach

Level 1

Duration: From initial training to three months post-training)

Objectives:

1. To provide in-depth monitoring and use of iREACH by users – Referral Specialists, CHWs, MHWs, and health care providers, e.g., physicians, physician assistants, family nurse practitioners and nurses.
2. To provide user feedback on iREACH system.

Quality Assurance Activities

Quality Assurance (QA) is a dynamic process and is utilized to identify needed process improvements – not as a punitive measure. Initial QA activities provide continual feedback to users, management and partner agencies on those areas of the processes that need attention, highlighting barriers to outcomes and identifying solutions. QA activities:

1. Ensure that all ACCEL iREACH users (Referral Specialists, CHWs, MHWs and health care providers) have been trained and monitored “live” while using the iREACH system application;
2. Include a methodical monitoring and tracking system to ensure compliance with all documentation required of users for each Pathway.
3. Create a process for iREACH users to contact the QA team with questions, problematic issues, guidance and direction on unusual client situations or difficulty with the iREACH application.
4. Confirm that iREACH users have been given written policies and procedures for all work specific to their use of Care Pathways, including HIPAA compliance. Agency partners and supervisors monitor iREACH Referrals and Care Pathways quality standards in order to evaluate staff performance.

Level 2

Duration: Ongoing process following Level 1 activities)

Objectives:

1. To provide intermittent “snap-shot” monitoring of iREACH users.
2. To provide user feedback on iREACH system.
3. To create QA tools for cross-agency partners and supervisors.

Quality Assurance Activities

QA is a continuous improvement process for all ACCEL partners. Strategies change as we monitor the ongoing use of iREACH to support each Pathway and achieve the anticipated results. Referral Specialists, CHWs and MHWs, who use the iREACH system daily, have provided significant feedback for improving the efficiency of the system that was designed to support their work activities.

Based on the successful completion of Level 1 Quality Assurance monitoring, the focus for Level 2 is to take a less intensive and more random “snap-shot” look at four individual Pathway milestones. (Specific Pathways and milestones selected for monitoring change every few months until all Pathways and milestones have been studied and then the QA process is repeated.)

Initial Level 2 QA efforts focus on the following four evaluation measures:

1. Accuracy of Milestone Closure

Evaluate how “unsuccessful” milestones are closed and being documented by CHWs and/or appropriate agency partners. This measure looks at three categories to produce a score. For every one of these milestones, there should be a “reason” and a “termination reason.”

2. Consistency of Pathway Documentation

Evaluate the documentation of pathways. This measure looks at three categories to produce a score. The overall intent is to make sure anyone can look at a Pathway and tell how far the CHW/MHW is in the Pathway, what activities have transpired and identify any current issues. This will be completed by looking at the following:

- Link to Pathway Referral: A critical link to reporting results of Pathway activities is that every Pathway has to be linked to a specific type of referral.
- Events: Each Pathway has a number of documented “events” for a given milestone. This is called Pathway Tracking – what is going on at a given point in time.
- Notes in Events: Most events contain a brief description of what activities have transpired or, at a minimum, provide a status.

3. Timeliness of Milestone Completion

This measure looks at the following: (1) those milestones whose due dates are late by at least seven working days and (2) the record has been updated to explain why it is late. This evaluation is for both CHWs/MHWs and partners.

4. Closeout of Appointments

This measure looks at client appointments in iREACH to ensure that all appointments have a final disposition, e.g., did the client attend or did not attend the appointment. Without this information, our reporting numbers will be off since two reports are based on appointments being kept.

Level 3

Duration: On-going

Objectives:

1. To identify cross agency community trends;
2. To resolve community barriers to successful completion of Care Pathways Activities; and
3. To identify additional Care Pathways that could be developed to meet community needs.

Overtime, we will identify emerging trends that impact the accurate and consistent use of iREACH by our agency partners. Our analysis (see next section on Reports) also helps to identify barriers that prevent the timely completion of particular Pathways or milestones. These evaluation results will be given to individual users, partner administrators, ACCEL program evaluators, and/or staff

management to provide feedback to overall ACCEL program managers and iREACH users for areas of improvement and future development.

Issue Resolution and Elevation Steps

Agency Supervisors are responsible for the day to day work of the Referral Specialists, Community Health Workers and Mental Health Workers. As issues are identified, they are evaluated by the Care Pathway Manager through informal discussions with the users or by the iREACH User Feedback/Questions form (See Appendix C). Every effort is made to address the problems quickly and thoroughly. As necessary, issues may be elevated to the appropriate level of Agency authority for resolution. This includes involving the Data Custodians and if unresolved, the Steering Committee, if it has a county-wide, multi-agency implications and/ or affects adherence to ACCEL policies and procedures.

Reports

iREACH data provides an opportunity to analyze the impact of Care Pathways in meeting the goals of the ACCEL Program:

- Improving access to health care and a “medical home;”
- Improving the quality and efficiency of the County’s health care systems
 - By identifying and resolving problems,
 - Tracking outcomes and addressing barriers; and
- Improving the ROI (return on investment) for El Dorado County’s community-based health organizations.

To date, the following reports have been developed to measure the impact of Care Pathways:

- Pathways Completed, Pending and Their Duration by Location
- Client Insurance Products Obtained by Location
- Pathway Referrals: Sources and Outcomes
- Client Pathway Status and Scorecard by Referring Provider Group
- Duration of Pathway Milestones: Expected vs Actual
- Appointment Outcomes by Provider Groups and by Individual Providers
- Pathway Success Rates by Referring Organizations
- Barriers to Pathway Completion