Whole Community Health: Lessons Learned through the Development and Implementation of Colorado’s HIE-Based Community Resource Network

INT5

Monday, August 9, 2021 2:30 PM - 3:30 PM

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Chief Technical Officer
Quality Health Network

Tess McInnis
Senior Project Manager
Quality Health Network

DISCLAIMER: The views and opinions expressed in this presentation are those of the author and do not necessarily represent official policy or position of HIMSS.
Meet Our Speakers

Marc Lassaux
Chief Technical Officer

Tess McInnis
Senior Project Manager
Conflict of Interest

Marc Lassaux
Tess McInnis

Have no real or apparent conflicts of interest to report.
Whole Community Health: Lessons Learned through the Development and Implementation of Colorado’s HIE-Based Community Resource Network

Agenda

• HIE and QHN
• The Three Domains
  • Medical
  • Behavioral
  • Social
• Bringing it all together
  • Community Resource Network
Learning Objectives

• Define the five key characteristics of a community that signify readiness for engagement in a coordinated care solution like CRN

• Summarize technology strategies used by CRN to integrate providers across the three domains of health, behavioral health and social determinants

• Illustrate outcomes and lessons tied to the Quadruple Aim as realized by the initial implementation experience of the CRN
About QHN

- Quality Health Network
  - Founded in 2004
  - Quality improvement organization
  - Secure HIE services in Western Colorado
  - 90%+ of providers participate
  - 100% of Hospitals participate
  - Behavioral Health, Long Term Care, Payers, Human Services, EMS, and many others
The QHN Network Today

- **Our Network**
  - 496 orgs
  - 29 EMRs
  - 100% of hospitals in our service area participate
  - 90+% of providers in our service area participate
  - 73% of patients have data in two or more systems

- **Total Lives Supported**
  - over 1 Million

- **Messages Routed**
  - over 113 Million
  - since 2015

- **QHN Users Today**
  - over 4,600

- **Event Notifications Delivered**
  - over 2.5 Million
  - since 2015
What We Do - Our Value

- Deliver data to EMRs
- Aggregate and analyze data
- Identify gaps in care
- Improve quality measure reporting
- Improve the ability to manage population health
- Enhance coordination of services
Medical Exchange Domain
WHY HIE?

Patients Move Between Providers…

*But their Data Doesn’t!*
Patient-Centered Data Home SHIEC
**HIE Value Adds**

- Comprehensive Clinical History
  - *Across care system boundaries*
- Real-time data delivery and notifications
  - “Subscribe” to patients across networks
- Quality Measure Reporting (eCQM) and HEDIS
- Foundation to Value Based Care
  - *Care Collaboration and Coordination*
Behavioral Exchange Domain
Behavioral Health Exchange

- Largest regional behavioral health centers
  - Share data via QHN with Consent!
- Receive data from QHN
- Active participants in HIE
Behavioral Health Exchange Value

- Reduce Manual Faxing
  - 61% reduction in faxes sent
  - 74% increase in electric data sent
- Increase Primary Care Assignment
  - Understand who does not have doctor
- Elevate status in Community
  - Easier to get data to and from facility
Social Information Domain
Social Information

- CMS Accountable Health Communities led by RMHP
  - [https://www.rmhpcommunity.org/ahcm/accountable-health-communities-model](https://www.rmhpcommunity.org/ahcm/accountable-health-communities-model)
  - Screen Medicaid, Medicare Beneficiaries
  - In Primary, Behavioral, Hospital Care Settings
  - Six Social Needs

The project described was supported by Funding Opportunity Number CMS-1P1-17-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. “The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.”
Social Information Screens

71,804 Total Screeners

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Social Information Needs

71,804 Total Screeners

Count and percent of screeners that were positive for each need, or had no needs. (Does not add up to 100% because screeners can be positive for more than one need.)

- no needs: 44,775 (62.4%)
- food: 17,083 (23.8%)
- housing: 11,405 (15.9%)
- transportation: 7,735 (10.8%)
- social isolation: 7,844 (10.9%)
- utilities: 5,357 (7.5%)
- safety: 2,071 (2.9%)

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Community Resource Network

[Diagram showing Medical, Behavioral, and Social components related to healthcare and community resources.]
Community–Wide Design & Collaboration
CRN Overview - Connecting People, Changing Lives

- Connects the teams
- Creates a whole-person picture
- Expedites help
- Optimizes well-being
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**CRN Demo**
A New Home in Record Time

Loren Couch, a case manager at Homeward Bound, recently reported,

We helped a struggling family get access to housing in one-third of the time it normally takes to place someone.
Thank You and Questions

- Marc Lassaux: mlassaux@qualityhealthnetwork.org
- Tess McInnis: tmcinnis@qualityhealthnetwork.org
- Communityresourcenet.org
- Qualityhealthnetwork.org
- Please complete the online session evaluation
The slides from here forward are only to be used if a live demo is not available.
Hello there!

Login to your account and start exploring.

By completing this attestation, I confirm my request for access to the CRN System to perform my job, and that I understand that any inappropriate access to or use of the CRN System may result in the imposition of sanctions against me, my supervisors and/or my organization that could include loss of use of the CRN System, notice to licensing authorities, and/or civil or criminal penalties.

By completing this attestation and signing into the CRN System, I understand, acknowledge and agree to the following:
- My access to the CRN system shall only occur by use of my unique User ID and password.
- I will keep my password confidential and not share it with anyone.
- I will not ask another user for their password.
- I will not login anyone else to the CRN System using my password.
- My access to and use of the CRN System, and use or disclosure of information from the CRN System, will be in compliance with QHIN Standards and all applicable laws.
<table>
<thead>
<tr>
<th>Client Name</th>
<th>Date</th>
<th>Task / Event</th>
<th>Status</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donaldson Victor</td>
<td>07/16/2021</td>
<td>Referral: Community Housing to Community Housing</td>
<td>Requested Community Housing</td>
<td>Routine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Referral: Community Housing to Grand Junction Housing Authority</td>
<td>Requested Grand Junction Housing Authority</td>
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</tr>
</tbody>
</table>

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**Hi Tessa Housing Admin McInnis**

**Jul 19, 2021**

Search

**Client Launchpad**

<table>
<thead>
<tr>
<th>CRN Search</th>
<th>Calls &amp; Walk-ins</th>
<th>My Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Recently Viewed Clients**

Donaldson Victor

Johnson John

Dubois Elaine

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**Tweets** by @QualityHealthN1

- **Quality Health Network**
  @QualityHealthN1
  - Exciting news for our participants and patients in western Colorado and Utah!
  - We've Got You Covered: New Link Between QHN
Various Assessments Taken
Accountable Health Communities Model (AHCM) is a program that connects patients with community and social service programs in addition to the health services from their healthcare provider. This includes programs that can help with housing, food, utilities, violence or transportation.

A. CORE POSITIVE NEEDS

- Living Situation

B. SUPPLEMENTAL POSITIVE NEEDS

- Financial Strain
- Support from Family & Community
- Mental Health

C. HI-RISK: More Than 2 ER Visits in Past Year

- Yes
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Victor's Social Connections Graph

<table>
<thead>
<tr>
<th>Shared HouseHold</th>
<th>Name</th>
<th>Relationship to Client</th>
<th>City/State</th>
<th>Preferred Method of Contact</th>
<th>Emergency Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jim Donaldson</td>
<td>Son</td>
<td></td>
<td>970-555-5555</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elaine Donaldson</td>
<td>Spouse</td>
<td></td>
<td>970-444-4444</td>
<td></td>
</tr>
</tbody>
</table>
Whole Community Health: Lessons Learned through the Development and Implementation of Colorado's HIE-Based Community Resource Network
Choose a Care Task

- [x] General Task
- [ ] New Case Note
- [ ] Manage Care Team
- [ ] Log or Express Referral
- [ ] Log Screener or Assessment

New Case Note

Note Name *

Household Update

Notes *

Victor and his wife have separated and Victor is in need of housing. We will be helping him apply for vouchers through.....

Save  Cancel
<table>
<thead>
<tr>
<th>Name</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tessa Housing Admin McInnis</td>
<td>Victor and his wife have separated and Victor is in need of housing. We will be helping him apply for vouchers through...</td>
</tr>
<tr>
<td>Tessa Housing Admin McInnis</td>
<td>Victor and his wife have separated and Victor is in need of housing.</td>
</tr>
<tr>
<td>Jackie Training</td>
<td>Looking</td>
</tr>
<tr>
<td>Jackie Training</td>
<td>Separated and with son...</td>
</tr>
<tr>
<td>Community Housing</td>
<td></td>
</tr>
<tr>
<td>Community Housing</td>
<td></td>
</tr>
<tr>
<td>Quality Health Network</td>
<td></td>
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</tbody>
</table>

Items per page: 20
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**HEALTHCARE SERVICES**

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care and Specialists*</td>
</tr>
<tr>
<td>Hospital Inpatient Care</td>
</tr>
<tr>
<td>Urgent or Emergency Care</td>
</tr>
<tr>
<td>Home Health &amp; Nursing Services</td>
</tr>
<tr>
<td>Outpatient &amp; Ambulatory*</td>
</tr>
<tr>
<td>Assisted Living &amp; Long-Term Care</td>
</tr>
<tr>
<td>Health Information &amp; Insurance</td>
</tr>
</tbody>
</table>

**COMMUNITY SERVICES**

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Services*</td>
</tr>
<tr>
<td>Family Services</td>
</tr>
<tr>
<td>Housing*</td>
</tr>
<tr>
<td>LGBT(+)</td>
</tr>
<tr>
<td>Youth Services</td>
</tr>
<tr>
<td>Education &amp; Literacy</td>
</tr>
<tr>
<td>Financial Assistance &amp; Benefits</td>
</tr>
<tr>
<td>Jobs and Training*</td>
</tr>
<tr>
<td>Transportation</td>
</tr>
<tr>
<td>Animal Services</td>
</tr>
<tr>
<td>Elderly Services*</td>
</tr>
<tr>
<td>Food Insecurity*</td>
</tr>
<tr>
<td>Law and Criminal Justice</td>
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<tr>
<td>Veterans Services+</td>
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</tbody>
</table>

**BEHAVIORAL HEALTH SERVICES**

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<tr>
<th>Service</th>
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</thead>
<tbody>
<tr>
<td>Mental Health Services*</td>
</tr>
<tr>
<td>Addiction and Substance Abuse</td>
</tr>
<tr>
<td>Self Harm or Suicide Prevention</td>
</tr>
</tbody>
</table>

Search by Keywords or add Demographic Criteria:

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Search agency name or keyword</td>
<td></td>
</tr>
<tr>
<td>Zip Code</td>
<td>81502</td>
</tr>
<tr>
<td>County</td>
<td>Mesa County</td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
</tbody>
</table>

[Search for Services button]
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**Service Provider Referrals**

**Community Housing**
Contact: 970-222-4444
Email: housing@communityhousing.com

**Grand Junction Housing Authority**
Contact: 970-245-0388
Email:
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Community Housing Referral Form

Date Created: 07/19/2021

Agency Sent From: Community Housing

Sent by: Tessa Housing Admin McInnis

Contact Phone: 720-470-3872

Electronic Referral

* Service Categories

- Housing

Referral Summary

- Age Group: Adult (18-64)
- Heath insurance status: VA Health
- Disabilities:
- Veteran: Veteran
- Housing Situation: Rent
- # in Household: 3
- # Under 18 in Household: 2
### Agency-Specified Referral Information

**Additional information**

---

### Required Documentation

- **Add documents to client doc vault**

Use the ‘Upload’ button to attach new documents. Click checkbox to add documents to the client doc Vault. Use the “From Doc Vault” button to attach documents that are already in the Document Vault.

- **Upload**
- **From Doc Vault**

---
### Client Launchpad

#### CRN Search
- Referral Shortcuts
  - Resource Directory

#### Calls & Walk-ins

#### My Resources

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- Make Referral Now
- Add To Referrals
- Make Express Hand Off
Client Demographics

- By Month
- By Gender
- By Age
- By Race/Ethnicity
- By Insurance Status
- By Housing Status
- By Education Level
- By Employment Status
- by Zip Code / Census Tract

Services & Referrals

- Referrals Received by Agency
- Referrals Received By Status
- Referrals Sent by Status
- Referrals Sent by Agency
- Declined Referrals Received by Racero