ONE UTAH
Health Collaborative

Organization Charter

One Utah Health Collaborative
July 2022

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Purpose & Governance

INTRODUCTION TO THE CHARTER

The purpose of this Charter is to guide the decisions of the board and executive director of the One Utah Health Collaborative (the Collaborative). The initial version of the Charter was informed by the work of the Organizing Body and Alignment Strategy facilitated between March and July 2022. The Charter complements the Collaborative's bylaws and will be revised over time.

ORIGINS OF THE COLLABORATIVE

For years, public and private leaders in Utah have known that the healthcare system will eventually require system-wide change. Healthcare costs have become increasingly less affordable over recent decades and appear poised to continue growing in the coming decade. The result will stunt Utah's economic growth as costs constrain employer profits, decrease employee wages, financially burden individuals and families, and crowd out other state spending priorities. Despite these rising costs, some important health outcomes measures are worsening, and disparities in healthcare continue to harm the state's most vulnerable populations.

In November 2021, Gov. Cox made a call to action to form a Collaborative comprised of community, employer, healthcare, and patient advocate leadership. This Collaborative will lead, collaborate on, and support innovation of Utah's payments and care delivery.

Following Gov. Cox's call to action, an Organizing Committee—made up of the Executive Committee, the Goals & Accountability Committee, the Innovation Committee, the Governance & Structure Committee, and the Data Committee—facilitated statewide community alignment efforts, developed recommendations for the Collaborative, and obtained 501(c)(3) status.

While the Collaborative was initiated by the Cox-Henderson administration, it is designed and intended to far outlast the administration's tenure. The challenges and opportunities for Utah's healthcare system are shared throughout the community. The Collaborative is the community's tool to achieve a healthcare system that aligns with Utah values.

VISION

The vision of the Collaborative is for Utah to be the national leader in cost-efficient, innovative healthcare, thereby strengthening its economic competitiveness and supporting a high quality of life for *all* Utahns. The Collaborative is a community-owned, public-private partnership that provokes system-wide change that no single entity can accomplish on its own.

TWO ROLES OF THE COLLABORATIVE

The Collaborative serves two primary roles. First, it aligns community leaders across unified goals, metrics, and a strategic plan for healthcare transformation. The unified goals will reduce the growth of healthcare spending while improving affordability and outcomes with a lens toward health equity. The Collaborative will partner with state and community stakeholders to track and monitor progress toward these goals, utilizing specific metrics, as well as facilitating the creation and maintenance of a strategic plan to achieve a healthcare system aligned with Utah values. The Collaborative will be a major player in accomplishing and measuring the goals and executing the strategic plan, particularly elements that require cross-disciplinary collaboration and shared infrastructure.

Second, it accelerates innovation. The Collaborative will identify and promote innovations taking place across the state. It will help current innovation efforts scale up to achieve broader reach and increased sophistication.The innovation support will primarily concentrate on select Priority Areas, which are recognized as important challenges that represent opportunities for collaboration.

GOVERNANCE

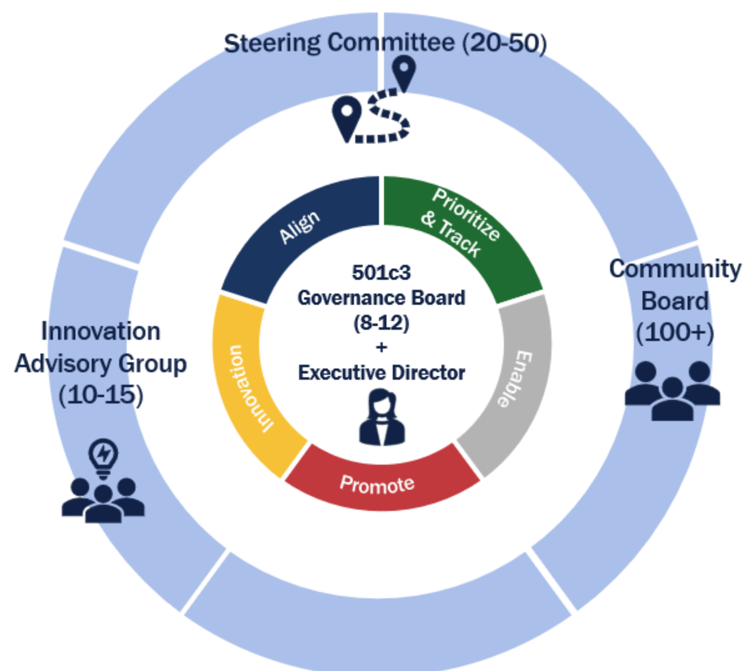
Organizational Structure

The governance and organizational structure of the Collaborative is designed to enable the two key roles of the Collaborative – to align diverse stakeholders and create synergy around common goals, metrics, and a strategic plan, and to accelerate innovation.

The collaborative is structured as a 501c3 nonprofit organization with an Executive Director and a small governance board called the Board of Directors. The organizational structure enables and supports engagement with key community stakeholders through a larger Community Board, consisting of key influencers and organizational representatives. A Steering Committee and Innovation Advisory Group are part of the

broader Community Board, though their role and makeup may be adapted under the direction of the Executive Director.

The voice of patients and consumers is formally incorporated into all decision-making bodies. The structure of that representation is determined by the Executive Director and Board of Directors, each of whom is committed to the Collaborative improving healthcare for patients and consumers. The structure for representation may include individuals serving as members who bring the patient and consumer perspective, and/or a formalized process for collecting feedback such as through patient and community advisory boards and committees. These boards may be formed by the Collaborative, or the Collaborative may work with existing boards and committees to serve this role.



Board of Directors
The Board of Directors ensures that the Collaborative organization is operating within the obligations and boundaries of a 501c3 to maintain its status as a nonprofit organization. The board also ensures that the collaborative meets any and all fiduciary responsibilities and provides support on basic functions of a nonprofit organization including legal, financial, human resources planning, and any additional functional type of support. As part of its fiduciary responsibility, the board will serve as stewards over the mission, vision, and charter as described here that the executive director must pursue. The board has direct responsibility for the performance, hiring, and firing of the executive director.

Members of the board should provide unique knowledge and operations of a 501c3 and serve as mentors and resources for the executive director. These individuals must have

a high level of “collaborative IQ” to support and drive the mission of the collaborative. The board of directors is not meant to be a large group, but rather a sufficiently sized group of appropriate individuals who can operate and perform the necessary functions of the board. The collaborative bylaws will be used to guide the functions and responsibilities of the board, including board terms, disclosing conflicts, etc.

Executive Director

The Executive Director is responsible for leading nonprofit management, cultivating community and stakeholder relationships, and ensuring mission-aligned outcomes are achieved. The Executive Director will lead the Collaborative’s staff and will report directly to the Board of Directors.

This position requires management of all programmatic functions and strategic plan developments, including but not limited to fundraising, marketing, and community outreach. The Executive Director is also responsible for upholding the Collaborative’s mission and strategy, ensuring the Collaborative remains financially viable through sound fiscal management, and manages organization-wide operations. The Executive Director is expected to demonstrate an advanced knowledge of the Utah healthcare landscape and have experience with healthcare innovation programs.

The Executive Director must be committed to envisioning the future of Utah’s healthcare ecosystem, possess high collaborative IQ, and is committed to achieving the goals of the Collaborative. This individual will be responsible not only for the management of the staff and operations of the 501c3 but also for managing the requests of the Board of Directors, and the interests of the Community Stakeholder Board.

Innovation Advisory Group

The Innovation Advisory Group is tasked with evaluating and making recommendations on the pilot programs the Collaborative will support, as well as specific mechanisms for doing so. Its efforts prioritize the Collaborative’s current Priority Areas and the strategic plan. The group approaches the effort systematically, transparently, and with accountability for the screening process. The group approaches its work with the understanding that innovation requires risk and accepts the reality that failures will be a part of the overall success of the Collaborative. This group will work to align recommendations with the Collaborative’s strategic plan.

This group is composed of 8-15 individuals representing a diversity of backgrounds, including across race and ethnicity, gender, stakeholder type (e.g., health system, payer, physicians, patients), and other differentiations. The members of this group also have a demonstrated ability to remain independent and neutral in the process of pilot

selection. Group members understand the grassroots nature of innovation diffusion and accept the facilitative role that the Collaborative plays in these efforts. The Executive Director selects its members with input from the Board of Directors and the Community Stakeholder Board.

Community Stakeholder Board

This group encompasses the entirety of the stakeholder community associated with the Collaborative. The Community Stakeholder Board is made up of individuals including those who have specific Utah healthcare expertise, influential community leaders, physicians, patients/consumers, and individuals with detailed subject matter expertise who will drive innovations forward in their individual organizations. The exact structure and layout of the Community Stakeholder Board will be guided by the Executive Director; however, this group should be a large group (up to 100 or more) to ensure wide representation.

Members of this board include those Utah healthcare stakeholders who have strong ties and connections within the Utah community. Members serve as representatives of their organizations or communities. Selection to the Community Member board is made by the Executive Director. The Community Stakeholder Board meets no less than twice annually. In these meetings, the Collaborative staff highlights recent successes, solicits community input, and discusses new potential pilot innovations. Once a year the collaborative holds an annual summit targeted to engage the broader community both locally and nationally to highlight the successes and achievements of the collaborative and build momentum and support for the subsequent year. Meeting format and agendas are set by the Executive Director.

Steering Committee (Subcommittee of the Community Stakeholder Board)

The steering committee serves a leadership function for the broader community stakeholder board. These individuals serve as the guiding body for engagement with the community board and are made up of trusted advisors and stakeholders who carry influence and reputation amongst the other community board members. The steering committee supports the executive director and is a voice for the goals, mission, and vision to the other members of the community board.

The steering committee will not be assembled at the onset of the collaborative, but will be formed by the executive director. Membership in this position and the duration of membership will be decided by the executive director.

Role #1 Community-Owned North Star

SCOPE OF THE COLLABORATIVE'S NORTH STAR ACTIVITIES

Work of the Collaborative

The Collaborative is responsible for setting and tracking statewide goals, including metrics for success. These statewide goals are the basis of the Collaborative's work and provide broad pillars for metrics and activities. The Collaborative facilitates ongoing monitoring of the established metrics and is responsible for the communication and messaging around the goals and metrics to gain public support for Collaborative efforts.

To achieve accountability, the Collaborative will gather commitments to this work from stakeholders. Initially, this has been done by collecting signatures on a pledge document that articulates the goals and principles of the Collaborative. Individual and collective accountability are facilitated by creating processes for individual partner organizations to self-report progress towards these statewide goals. The Collaborative encourages collective accountability by providing mechanisms for organizations to share progress, updates, barriers, and outcomes.

The Collaborative is also responsible for developing and maintaining a 15-year strategic plan. This plan describes the desired future state of Utah's healthcare system and the independent and collective steps necessary to achieve them.

Work of the Stakeholder Community

All stakeholders, including patients, are involved in the process of setting goals and metrics for the collaborative. The three statewide goals which were chosen through stakeholder alignment during the organizing process are anticipated to be the broad goals of the Collaborative for at least 15 years. Should it become necessary to change these goals, a similar process will be implemented to ensure community representation.

Stakeholders have committed to working towards statewide goals by signing the pledge document that articulates the goals and principles of all involved in this work. Stakeholders participate in individual and collective accountability by reporting on progress, barriers, and outcomes related to the broad goals.

STATEWIDE GOALS & METRICS

The overall objective of the Collaborative is to **reduce the growth of total healthcare spend in the state.** However, this is not done at the expense of other Utah values. Reducing the growth of healthcare spending is aligned with the shared goals of strengthening affordability and high-quality outcomes and underscored by equity. The Collaborative is the steward of specific metrics associated with these goals. The metrics and goals *may* consider:

Total healthcare spend:
- Medical expense paid to providers
- Patient cost sharing
- Cost of private insurance

Affordability:
- Health spend as a percentage of:
  - employer benefit expenses,
  - individual and family incomes, and
  - state government budget
- Utahns health insurance coverage

Outcomes:
- Health behaviors
- Clinical care rates
- Quality of life
- Mortality rates
- Disease prevalence

Equity:
- All metrics are stratified by race, ethnicity, sexual orientation, gender identity, ability, and geography

Process for Setting and Tracking Metrics
The Collaborative coordinates the process for selecting and defining metrics, establishes the baseline, and sets targets for improvement. This process is open to contributions from the many stakeholders who will be influential in seeing success.

The Collaborative is the owner of a statewide and, where possible, a regional scorecard. The scorecard has a baseline measure of health and its associated costs. The tool aligns with the broad goals of the Collaborative and includes metrics in the categories of affordability, outcomes, and equity, as well as an overall cost growth metric.

The Collaborative helps to marry the public and private interests of entities within the state and surfaces concerns, ideas, and innovations related to the scorecard. Data for tracking and calculating metrics may be housed and analyzed by the state, though the collaborative plays an integral role in helping to develop and define the scorecard, aligning its purpose with the accepted overarching goals, and communicating results. The Collaborative works closely with the Department of Health and Human Services (DHHS) on tracking metrics.

Principles for Setting and Maintaining Goals and Metrics
When adding, replacing, or updating the goals and/or metrics, the Collaborative considers the following:

- **Actionability, Timeline, and Scalability—**Goals and metrics are both actionable and achievable within the 15-year timeframe and will have a measurable impact.
- **Community Input and Patient Focus—** The healthcare system needs to work for patients, so all goals and metrics keep the patient and consumer as the focal point.
- **Alignment with DHHS—**The Collaborative works closely with DHHS when modifying or adding new goals and metrics.
- **Agreed upon Framework—**The process of identifying new goals and metrics or modifying existing goals and metrics is carried out within a framework that is agreed upon by those involved in the goal setting process. This framework helps establish an agreed upon understanding of how Utah's healthcare system operates and what the drivers of health are.
- **Messaging and Public Buy-in—**Because the goals and metrics are community-owned and impact the public, any changes to the goals and metrics are intentionally messaged to gain public support.
- **Equity—**When tracking metrics, data is broken down by demographics (race, ethnicity, sex, geography, language, gender identity, sexual orientation).

COMMITMENTS AND ACCOUNTABILITY
Pledge Document
The pledge serves as an expression of accountability for individuals and organizations and identifies the principles required for successful collaboration. In signing the pledge, stakeholders have aligned themselves with the broad goals of affordability, equity, and outcomes. These broad statewide goals are the foundation of the Collaborative's work and provide broad pillars to arrange metrics and activities around. Stakeholders are dedicating resources to influence their spheres, participate in shared accountability, and engage in collaborative efforts towards accomplishing these goals. The pledge commits stakeholders to a unified approach to system-wide change that makes Utah a healthier place to live, work, and play. The three broad goals identified in the pledge that guide the Collaborative's work are:

Affordability: Utah will lead the nation in affordable healthcare for employers, state government, and every individual.

Outcomes: Utah will have the healthiest population in the nation.

Equity: Utahns will receive equitable healthcare regardless of race, ethnicity, sex, geography, or background.

The pledge lives on the One Utah Health Collaborative website indefinitely. Signatories' names/organizations are listed (by organization logo, when possible) on this page.

Guiding Principles

As stakeholders work towards the statewide goals, it is important that they abide by a set of shared principles to create meaningful and lasting change. These principles provide guidance and intentionality in how stakeholders will approach their work.

Organizations that sign the pledge commit to abide by the following guiding principles:

1. **Build trust**
We will establish and strengthen trust among health influencers including patients, health and social care providers, payers, employers, public servants, innovators, and all those who affect the health of Utahns.

2. **Individual and collective action**
We will participate in individual and collective action to meaningfully pursue these goals and address the systematic structures that create barriers to progress.

3. **Patient and Consumer Focus**
All efforts through the Collaborative will have the welfare of patients, purchasers, and taxpayers as the central priority.

4. **Elevate community voices in decision-making processes and activities**
We will work to not only include, but amplify, the views and contributions of all of Utah's communities. We will ensure that all Utahns are heard.

5. **Collaborate across sectors**
We will engage in collaborative activities with a diversity of actors across the health and social services industries to create common priorities, shared measures, and work toward these goals.

6. **Prioritize strategies for systems-level change**
Recognizing that lasting change happens at the systems level, we will commit to prioritizing innovations that improve structural, social, and service norms systemwide.

7. **Practice transparency**

We will prioritize transparency, clarity, and trust, as we shine a light on opportunities for improvement. Data will be used to iteratively learn, adapt, and improve our healthcare system and the outcomes for Utahns.

8. **Design and implement activities with a priority placed on equity, diversity, accessibility, and inclusion**

Equity, diversity, accessibility, and inclusion will be at the center of decision-making processes and activities that we engage in. We will be intentional in developing strategies that focus on improving health for all populations.

9. **Engage in shared accountability**

We will hold ourselves and each other accountable for the actions we have committed to in pursuit of these goals.

PRINCIPLES FOR DEVELOPING A UTAH STRATEGIC PLAN

The Collaborative is responsible for facilitating the development of a 15-year strategic plan for Utah to work towards the described goals. The strategic plan provides the Collaborative with a roadmap to align its functional activities with its vision, goals, and the specific metrics associated with those goals. The purpose of the strategic plan is to provide clear guidance to both the Collaborative and stakeholders as they work towards the shared goals, both independently and as a collective group.

The following principles are followed during the development of a strategic plan:

- **Stakeholder input—**Equitable stakeholder input will be a key element of the process.
- **Community values:** The strategic plan will reflect the values of community members. These values must align with the design of the health system that we collectively aspire to create.
- **Sufficient timespan—**The strategic plan will be developed along a timespan that is sufficient for gathering meaningful stakeholder input and gaining consensus on the plan.
- **Periodically updated—**The Collaborative will periodically review the strategic plan to ensure it continues to align with the Collaborative's vision and goals and adjust as needed.
- **Scope and Actionability—**In creating the strategic plan, ensuring a reasonable scope and actionable ideas will be prioritized.

Role #2: Accelerating Innovation

SCOPE OF THE COLLABORATIVE'S INNOVATION ACTIVITIES

Work of the Collaborative

The Collaborative is responsible for identifying, supporting, and promoting promising innovations taking place across the state or country that have the potential to increase overall health, reduce costs, and attain equity. The Collaborative is not the administrator of innovations, nor is it intended to implement new innovative efforts; its primary role is facilitative, allowing the work already being done across the state to scale up to achieve broader reach and increased sophistication.

In pursuit of these efforts, the Collaborative has a process for identifying innovations which should be supported and based on a set of quantifiable metrics and informed by stakeholders needs. In keeping with the spirit of innovation, however, the process remains flexible enough to accommodate non-traditional interventions. The Collaborative will also maintain a role in ensuring accountability for resources provided to innovators.

The effectiveness of the Collaborative is, in part, predicated upon its ability to deploy data capably across its various initiatives. This process requires the collection, analysis, and interpretation of data. The Collaborative will be well equipped with expertise and technological assets, which facilitate this exercise of advancing innovations. Those serving data roles within the Collaborative participate in this process by helping to identify measurements and data sources, proposing tools for the collection and analysis of data, and aiding in outreach.

The Collaborative conducts its activities with inclusion in mind. This includes creating a process for selecting innovations to support with the voice of a diverse set of community stakeholders and making efforts to ensure the representation of smaller and under-resourced innovations.

Work of the Stakeholder Community

It is imperative to the success of the Collaborative that stakeholders are meaningfully engaged at every stage. To identify gaps in the current innovation landscape and promising programs that would flourish if provided the support the Collaborative offers, the Collaborative communicates frequently with stakeholders across the community. Additionally, the stakeholder community plays a role in selecting the innovative programs and services the Collaborative supports. While the ultimate number of innovations supported by the Collaborative depends on the resources and funding available, selected innovations are prioritized based on their alignment with the Collaborative's Priority Areas and an understanding of the needs of the community.

Stakeholders also play a supportive role. Organizations that have signed a pledge to work toward common goals are a resource to the organizations and individuals seeking support through the Collaborative. The Collaborative draws upon this network to enter partnerships that support the innovations. Pledgees can be drawn upon as partners to enhance and expand innovations across the state.

IDENTIFYING INNOVATIONS TO SUPPORT

When designing the process for identifying innovations that the Collaborative will support through promotion, partnership development, grant funding, or other means, the following principles are followed:

- Diversity in the board/committee/group of volunteers that identify and select projects.
- Continued monitoring of the state landscape to identify programs in need of support.
- Accessibility in the process of applying for innovation support, and transparency regarding the selection process.
- Prioritization of innovations that align with the goals and priorities of the Collaborative. When prioritizing which innovations to support, the Collaborative will:
    - Prioritize innovations with the ability to scale.
    - Consider impact across stakeholders.
    - Recognize that financial savings is not the only important outcome.
    - Consider innovations that could be piloted in Medicaid, state employees, or other populations where the Collaborative might have more direct ability to influence adoption.
    - Prioritize innovations that use data to track outcomes.

STRATEGIES FOR SUPPORTING AND PROMOTING INNOVATIONS

Supporting Innovations

A primary role of the Collaborative is to support innovations already happening in the state. There are several types of financial and non-financial support the Collaborative offers to the selected innovations, which include (but are not limited to):

- Facilitate connections between stakeholders
- Provide publicity and marketing
- Support with grant funding expertise
- Provide project management and strategic planning services
- Fund innovations and pilot programs
- Evaluate innovations

Promoting Innovations

The Collaborative promotes new and existing innovations in the state. Most innovation happens with limited participants and may be redundant with other initiatives. The

Collaborative amplifies awareness of these innovations to attract additional participants, inspire the creation of similar or even enhanced initiatives, and create an atmosphere of collaborative innovation across the state. Additionally, the health innovation in Utah will have relevance to other states and nationwide efforts to improve healthcare. The Collaborative promotes innovation in several ways, including:

- Publish content spotlighting innovations
- Create case studies on successful programs
- Host conferences and events
- Create a peer learning community
- Host a podcast series
- Leverage local news outlets including radio and television

When supporting innovations through publicity and marketing, the Collaborative considers the following:

- Align messages across organizations
- Build community and provider education/buy-in
- Lean on the expertise of local board members and local leaders
- Target a variety of channels
- Share what matters
- Collect input from across geographies and demographics

DATA ANALYSIS TO SUPPORT INNOVATION

Data analysis and evaluation is an integral part of identifying, assisting, disseminating, and measuring impactful healthcare innovation happening throughout the state. The process used to evaluate innovation utilizes a data framework to assess statewide health gaps, and then identify, validate, and support those innovations.

PRIORITY AREAS

Purpose of Priority Areas

To achieve the greatest impact, the Collaborative selects a limited number of Priority Areas that guide the activities of the organization, primarily the innovations, but also direct resources devoted to convenings, alliances, reports, and policy recommendations.

While most efforts of the Collaborative should be within the realm of these Priority Areas, an exception is the concerted promotion of the varied innovation happening across the state. The Collaborative is responsible for promoting solutions and innovations of any type that advance the broad goals of the Collaborative.

Criteria for Selecting Priority Areas

The selection and revision of Priority Areas considers: 1) the unique needs of the Utah population, and 2) areas that are best influenced by the tools the Collaborative provides, namely cross-stakeholder collaboration, research, innovation, and promotion. The

process for identifying the original priority areas included a broad gathering of input from the community and expert input. As the challenges that Utahns face change over time, priority areas will need to be reevaluated. There may be shifts in what community members identify as important, as well as changes in Utah's healthcare ecosystem that impact health needs. When reevaluating priority areas, the Collaborative follows a process that prioritizes stakeholder input and community engagement.
The ultimate and modification of priority areas is informed by stakeholder input but decided by the Executive Director and board of directors.

Initial Priority Areas of the Collaborative
The initial priority areas for the Collaborative are:

- **Primary care** - Utahns have and use access to preventative and primary care.
- **Behavioral health** - Utahns have intuitive access to integrated behavioral health care.
- **Data infrastructure** - Utahns personal health records are fully available to them and to those who care for them to improve health outcomes and reduce the expense of duplicate care.
- **Coverage and access** - Utahns have appropriate health insurance coverage to access the health services they need.

Appendices

APPENDIX A: MEMBERS OF THE EXECUTIVE COMMITTEE OF THE ORGANIZING BODY

Executive Committee members are committed to the vision for the future of Utah's healthcare. These individuals were chosen based on their commitment to the vision, their high collaborative IQ, their demonstrated work to address health equity, and other characteristics listed in the selection criteria. Members are selected for being community-minded and are not representing their current organizations or affiliates.

The Executive Committee is responsible for solidifying the mission, values, and strategy and is accountable to Gov. Cox's charge to form the Collaborative. Committee members act as public representatives and advocates for the Collaborative and ensure decisions are patient-driven, consensus-based, and meet the needs of Utahns. Throughout the organizing phase, members of the Executive Committee facilitated aspects of the alignment tour, oversaw committee work, selected priority areas, and assisted with the development of the Collaborative's charter and recommendations.

Committee Members

Member	Organization	Role
Scott Barlow	Revere Health	Member
Greg Bell	Utah Hospital Association	Member
Marc Bennett	Comagine Health	Member
Amanda Covington	Larry H. Miller Group of Companies	Member
Gov. Spencer J. Cox	Utah Governor	Convener
RyLee Curtis	University of Utah Health	Member
Natalie Gochnour	Kem C. Gardner Policy Institute	Goals & Accountability Committee Chair
Sebastian de Freitas	SelectHealth	Member
Dr. Michelle Hofmann	Utah Department of Health and Human Services	Member
Chris Klomp	PointClickCare	Data Committee Chair
R. Chet Loftis	PEHP Health & Benefits	Member
Rich McKeown	Leavitt Partners	Governance & Structure Committee Chair
Ryan Morley	SpringTide	Executive Committee Co-Chair
Dr. Shannon Connor Phillips	Intermountain Medical Group	Innovation Priorities & Process Committee Chair
Rich Saunders	Office of Spencer J. Cox at the State of Utah	Executive Committee Co-Chair

Betty Sawyer	Project Success Coalition	Member
Oreta Tupola	Utah Public Health Association	Member
Dr. Sarah Woolsey	Association for Utah Community Health	Member

APPENDIX B: RECOMMENDATIONS FROM THE COMMITTEE ON GOALS AND ACCOUNTABILITY

In order to support the development of the One Utah Health Collaborative, the Goals & Accountability Committee has proposed the following series of recommendations. These recommendations are based on information gathered by stakeholder forums conducted with patients, community-based organizations, payers, care delivery representatives, and employers as well as thoughtful discussion between the experts represented on the Goals & Accountability Committee. While developing the business plan for the One Utah Health Collaborative, the Executive Director and team should use these recommendations to guide the Collaborative's activities and strategy related to goals and accountability.

Goals & Accountability Committee Membership

Selection

Committee members were selected from the pool of applications submitted via the state's website, as well as individuals identified as key opinion leaders during an initial landscape assessment. The criteria and expertise that were sought after included: knowledgeable of healthcare metrics, healthcare innovation, program evaluation, an understanding of public health, an understanding of Utah's healthcare systems and stakeholders, collaborative attitude, and ability to think big picture. The House Speaker and Senate President appointed two legislative representatives.

Committee Members

Member	Organization	Role
Natalie Gochnour	Kem C. Gardner Policy Institute	Committee Chair
Bill Crim	United Way of Salt Lake	Co-chair
Brent James	Stanford	Member
Melissa Zito	UDOH	Member
Jill Parker	Utah Association of Local Health Departments	Member
Matt Slonaker	Utah Health Policy Project	Member
Dan Lofgren	Cowboy Partners	Member
Rep. Ray Ward	Utah State Representative	Legislative Representative
Sen. Mike Kennedy	Utah State Senator	Legislative Representative

Goals & Accountability

Scope of the Collaborative's Goal-related Activities

Role of the Collaborative

The Collaborative will be responsible for setting community goals, including metrics for success, ongoing monitoring of metrics (refer to the Data Committee's Inputs for the Collaborative Charter document for more details), and reporting to necessary stakeholders (such as the legislature), as well as for determining priority areas for the Collaborative to focus activities on. The Collaborative should also be responsible for the messaging associated with the community goals and strategic plan and will be expected to prioritize community and stakeholder input as well as gain public support of goals and priority areas.

The 15-year strategic plan will be developed and maintained by the Collaborative, as well as the pledge.

The Collaborative will also facilitate individual and collective accountability by creating processes for individual organizations working with or receiving funding from the Collaborative to provide regular reporting on key metrics. The Collaborative will encourage collective accountability by providing mechanisms for organizations to share progress, updates, barriers, data, and outcomes. Depending on the governance structure of the Collaborative, this may consist of convening alliances, establishing the ability for organizations to easily report progress and share data, and/or hosting events to facilitate transparent sharing between organizations. The Collaborative will also own, outsource, or a hybrid of the two, the measurement and evaluation of innovations to ensure that organizations are working towards the goals they have committed to. Additional details can be found in the Data Committee's Inputs for the Collaborative Charter document.

Role of the Stakeholder Community

All stakeholders, including and especially the community, must be involved in the goal setting process. It is anticipated that the three goals that were set during the organizing process will be the broad goals of the Collaborative for at least 15 years, but should it become necessary to change these goals, a stakeholder alignment process like the one used during the organizing process may be implemented to ensure community and stakeholder representation. This would involve stakeholder forums, surveys, and ad hoc discussions.

As the Collaborative begins working towards the goal in earnest, it will be important to put community and patient needs and priorities at the center of decision-making. One approach the Committee recommends is to establish a community advisory group to engage with the Collaborative on a regular basis to discuss the needs and priorities of the community, as well as to solicit feedback on the activities of the Collaborative. This will help to center the community's voice beyond the initial development of the

Collaborative. There may be other approaches to achieving this objective. The Board of Directors and Collaborative staff will have discretion in how they act on this.

Process for Setting and Maintaining Community Goals
The Collaborative will be the steward of community-owned goals. The goals have been placed into three categories:

Affordability	**Equity**	**Outcomes**
Utah will lead the nation in affordable healthcare for employers, state government, and every individual.	Utah will provide equitable healthcare to all regardless of race, ethnicity, sex, geography, or background.	Utah will have the healthiest citizens in the nation.

It is recommended that the process of identifying new goals or modifying existing goals be led by the Collaborative's Board of Directors, with input and involvement from various entities, such as a community advisory group, DHHS, etc. (described below).

- **Actionability/Timeline/Scalability—**The Collaborative should consider goals that are both actionable and achievable within the 15-year timeframe, as well as goals that can have a measurable impact.
  - **Simplicity is scalable—**make sure that goals and metrics are accessible to a wide audience.

- **Community Input and Patient Focus—**The healthcare system needs to work for patients, so any new goals should keep the patient and consumer as the focal point. This may be done by hosting listening tours, focus groups, and deploying surveys to gain insight from patients and consumers on their priorities and needs. Secondary research should also be done using available literature to determine strategies for placing the patient at the center of goal setting. Asking the question "Will this goal get us to a place where patients/consumers are better off than they are now?" is a helpful approach.

- **Alignment with DHHS—** The Collaborative should work closely with DHHS when modifying or adding new goals. DHHS sets its own goals and defines metrics for monitoring success, and the Collaborative's goals should not only align with these goals and metrics, but the Collaborative and DHHS's goals should be mutually reinforcing and supportive of each other. DHHS staff should be highly involved in the process of modifying goals, with at least one representative involved in a formal/official capacity. It is preferable that a representative from the Office of Healthcare Statistics also be involved in the goals process.

- **Agreed upon Framework—**The process of identify new goals or modifying existing goals should be carried out within a framework that is agreed upon by those involved in the goal setting process. This framework should establish an agreed upon understanding of how Utah's healthcare system operates and what the drivers of health are. Questions that the framework should be able to answer include:
  - What are the primary drivers impacting health outcomes?
  - What are the biggest barriers to an effective healthcare system?
  - What are the primary drivers of healthcare costs?

  Any changes to the goals or new goals should be within the parameters of this framework. For example, if it is agreed upon that health behavior is one of the most important drivers of health outcomes in Utah, the Board should consider if new or modified goals have the potential to be meaningful by impacting health behavior. This agreed upon framework can be established by the Board of Directors and informed by secondary research. The framework will help to ensure that new goals will be within the realm of what will have a measurable impact on healthcare or health outcomes.

- **Messaging and Public Buy-in—**Because the goals are community-owned and will impact the public, any changes to the goals should be intentionally messaged to gain public support. This is especially important if any of the major goals are changed. The Collaborative should rely on their marketing and public relations staff to generate the right content to communicate what the goals are, why they were modified/replaced, what the expected impact of this change is, and how the public can help to support these goals.

- **Political Viability—** It is recommended that political viability be carefully considered when making any changes to the goals. The Collaborative is a public-private partnership, and it will be essential to have the continued support of the executive and legislative branch. Consulting with elected officials at the state level, as well as continued communication with the governor's office, will provide insight into priorities and barriers that may impact the Collaborative's goals.

- **Metrics—**When tracking metrics, break data down by demographics (race, ethnicity, sex, geography, language, gender identity, sexual orientation)

Process for Individual and Collective Accountability

Pledge document

The pledge will live on the One Utah Health Collaborative website under a page titled "One Utah Health Collaborative Compact" indefinitely. Signatories' names/organizations

will be listed (by organization logo, when possible) on this page. It is recommended that new signatories can add their names via an online form and that a Collaborative staff member review the form submissions on a regular basis and add additional signatories to the webpage.

The pledge will be date stamped. Should the three statewide goals of affordability, equity, and outcomes and/or principles be modified, language will be added to the pledge webpage indicating that the goals have been updated and the signatories shown are associated with the original version of the pledge.

Gathering new signatures is not necessary if the goals change but gaining public support will be important.

Process for Accountability
Individual: It is recommended that organizations contracting directly with or receiving funding from the Collaborative be required to regularly report on key metrics and to share data with the Collaborative staff. The specifics of this will depend on the data governance structure of the Collaborative as well as on individual contracts with outside organizations. The Collaborative's data-related activities will provide structure around the process of working with organizations on a 1:1 basis to achieve transparency and data sharing.

Collective: The Collaborative will encourage collective accountability by providing mechanisms for organizations to share progress, updates, barriers, data, and outcomes. The specifics of collective accountability depend on the governance structure of the Collaborative and may consist of the following:

- Convening alliances: Alliances of similar stakeholder groups can provide an opportunity for organizations with similar interests and priorities to work together towards certain goals, reduce redundancies, and collaborate in measuring success.
- Establishing the ability for organizations to easily report progress and share data: Publicity can support accountability to goals. It is recommended that the Collaborative create a way for organizations to provide updates on their activities, such as quarterly success metrics, that the Collaborative can make public via the Collaborative website and other media.
- Hosting events to facilitate transparent sharing between organizations: It is recommended that the Collaborative host an annual "goals summit" to bring organizations together and facilitate presentations, workgroups, and technical assistance related to the measuring of goals.

The Collaborative will also own, outsource, or a hybrid of the two, the measurement and evaluation of innovations to ensure that organizations are working towards the goals they have committed to. Refer to the Data Committee's Inputs for the Collaborative Charter for details.

Measuring success

Process for Developing a Utah Strategic Plan

Refer to the Governance Committee's Inputs for the Collaborative Charter document for details on the governance structure of the Collaborative and more details on the process for developing a strategic plan.

The Collaborative will facilitate the development of a 15-year strategic plan for Utah to work towards the described goals. The purpose of the plan is to unify the state around a unified approach. This plan will also give greater direction to the activities of the Collaborative.

Important Considerations for Creating a Strategic Plan:

- Establish equitable stakeholder input
- Form a manageably sized work group: a small (no more than 10) group of individuals should be selected from the Board to work together on an initial draft of the strategic plan
- Determine the scope and actionability of activities within the plan
- Work with a strategic planning consultant during this process

Resources to Support Goals

Staffing

The Goals & Accountability Committee does not recommend that the Collaborative hire specific individuals to support the goals process. Creating goals, updating goals, measuring success, and achieving accountability are responsibilities that will be dispersed among the Collaborative's staff and Board of Directors. Three entities will have the most involvement with these responsibilities, and the goals-related aspects of their work are described in the table below.

Role	**Qualifications**	**Job Responsibilities (specific to goals)**
Executive Director	See Executive Director job description	• Make final decision on changing or modifying statewide goals, based on recommendations from the Board of Directors
Board of Directors	See Board of Directors job description	• If necessary, vote to change or modify statewide goals and pass recommendations

		for these changes to the Executive Director • Develop 15-year strategic plan
Senior Data Analyst	Refer to the Data Committee's Inputs for the Collaborative Charter document.	

In general, it is recommended that the Executive Director and team consider individuals and groups who are involved in the goals, measuring, or accountability processes have an understanding of Utah's healthcare system and health outcomes, willingness to collaborate, and a commitment to ethical practices. DHHS staff should also be highly involved in this process, especially an individual from the Office of Healthcare Statistics.

Outside Contracting/Resources

Based on the recommendations made by the Goals & Accountability Committee, the Executive Director and team should consider the following additional resources to support this work:

Function	Description of Requirements
Public communications	If the Collaborative does not hire marketing or public relations staff, it is recommended that they consult with an outside expert to ensure that the public communication around the Collaborative's goals, objectives, and strategic plan are done in such a way that public support is established.
Strategic planning consultant	As the Collaborative develops a 15-year strategic plan, it is recommended that they contract with an outside consulting firm who can guide the strategic planning process. The small workgroup that is tasked with the initial draft of the strategic plan will be the only group involved with the strategic planning consultant.

Priority Areas

Scope of the Collaborative in setting Priority Areas

Role of the Collaborative

The Collaborative will select priority areas that will guide the activities of the organization, primarily the innovations, but also focus efforts on convenings, alliances, and policy recommendations. The committee recommends that the process of selecting and updating priority areas consist of conducting a survey of stakeholders to

identify priority areas, secondary research, discussion and a vote from the Board of Directors and final approval by the Executive Director.

Role of the Stakeholder Community
Community members are an essential part of identifying and updating priority areas. The committee recommends that a stakeholder survey be fielded to a broad stakeholder group that would include patients, payers, providers, and community-based organizations. The survey would ask stakeholders to identify 3-5 priority areas from a thorough list (mental health, primary care, aging services, suicide, preventive screening, etc.). Survey results would be analyzed to identify what priority areas rise to the top. The Board of Directors would vote on three priority areas to recommend to the Executive Director that represent community priorities.

Process for Identifying and Updating Priority Areas
The Alignment Strategy during the organizing phase of the One Utah Health Collaborative provided avenues for meaningful feedback from varied audiences. Ultimately, the Collaborative is meant to be community-owned and a public-private partnership that provokes system-wide change. Because the Collaborative is meant to address community-wide needs, it must reflect community input, both from traditional and non-traditional healthcare stakeholders. Input from this process has been continuously disseminated to and utilized by relevant committee members throughout the organizing phase of the Collaborative.

The Goals and Accountability Committee was tasked with reviewing the inputs listed above and identifying themes and common recommendations. Two individuals volunteered to read through the survey data to identify 3-5 primary themes as a recommendation for Priority Areas. These individuals recommended the priority areas to the Goals and Accountability committee, which endorsed the priority areas. A limitation to the methodology used in this analysis is that the data reviewed was limited to data collected through the survey process. This is the same data that was used in the quantitative analysis. The individuals did not review any input provided through the Large Stakeholder Forums or the Ad Hoc Forums.

Additional quantitative and qualitative analysis of the inputs was also conducted to identify themes and inform a list of recommended priority areas. Please refer to the *Appendix K: Alignment Strategy Inputs Analysis* for detail on this process and the results.

APPENDIX C: RECOMMENDATIONS FROM THE COMMITTEE ON INNOVATION

In order to support the development of the One Utah Health Collaborative, the Innovation Committee has proposed the following series of recommendations. These recommendations are based on information gathered by stakeholder forums conducted with patients, community-based organizations, payers, care delivery representatives, and employers; interviews held with individuals overseeing innovations currently underway across the state; and thoughtful discussion between the experts represented on the Innovation Committee. While developing the business plan for the One Utah Health Collaborative, the Executive Director and team should use these recommendations to guide the Collaborative's strategy related to identifying, enhancing, expanding, and promoting innovation across the state.

Innovation Committee Membership

Selection

Members of the Innovation Committee were selected from the pool of applications submitted via the state's website, as well as individuals identified as key opinion leaders during an initial landscape assessment. The Innovation Committee sought out members that represented diverse stakeholders including payers, several types of providers, and those working in public or population health. Having members that represented both rural and urban geographies was also priority, particularly given the unique challenges facing rural Utahns. Finally, the Committee sought varied expertise, across evaluation efforts, alternative payment models, and care interventions. To ensure an innovative mindset from the Committee, members were selected with experience in different areas of care interventions, including upstream interventions, downstream interventions, clinical interventions, and interventions that address social needs.

Committee Members

Member	Organization	Role
Shannon Connor Phillips, MD, MPH	Intermountain Healthcare	Committee Chair
Peter Weir, MD	University of Utah	Member
Mary Jo McMillen	Utah Support Advocates for Recovery Awareness	Member
Marcie Baxter	Dignity Home Health and Hospice	Member
Jennifer Strohecker, Pharm D.	Utah Department of Health	Member
Eric Cragun	Castell	Member
Donna Milavetz, MD, MPH	Regence Blue Cross Blue Shield	Member
Carrie Butler	Utah Public Health Association	Member
Andy Almeida	Deseret Mutual Benefit Administrators	Member

Scope of the Collaborative's Innovation Activities

Role of the Collaborative

The Collaborative will be identifying, supporting, and promoting promising innovations taking place across the state that have the potential to increase health, reduce costs, and pursue equity. The Collaborative is not the administrator of innovations, nor will it be implementing new innovative efforts; its role is facilitative, allowing the work already being done across the state to reach higher levels of sophistication and reach.
In pursuit of these efforts, the Collaborative should adopt a process for identifying innovations to support that is based on a set of quantifiable metrics and informed by barriers surfaced by stakeholders. In keeping with the spirit of innovation, however, the process should remain flexible enough to accommodate non-traditional interventions.

The Collaborative must also maintain a role in ensuring accountability for the provision of state resources to innovators. To achieve success, the Collaborative must be willing to accept some level of risk in the innovations it supports. The success of the Collaborative should not be tied to the success of any one initiative; resources should be spread across multiple innovators, with the expectation that some innovations will fail.

The Collaborative should undergo its activities with inclusion in mind. This includes creating a process for selecting innovations to support with the voice of a diverse set of community stakeholders and making efforts to ensure the representation of smaller and under-resourced innovations.

Role of the Stakeholder Community

It is imperative to the success of the Collaborative that stakeholders are meaningfully engaged at every stage. In order to identify gaps in the current innovation landscape and promising programs that would flourish if provided the support the Collaborative offers, the Collaborative should communicate frequently with stakeholders across the community using a Community Liaison. This individual, hired by the Collaborative, should maintain a network of key opinion leaders across the state to guide the efforts of the Collaborative.

Additionally, the stakeholder community should play a role in selecting the innovative programs and services the Collaborative will support. As part of the selection process, a representative committee of volunteers from the community should prioritize the requests for support submitted to the Collaborative. While the ultimate number of innovations supported by the Collaborative will depend on the resources and funding available, this committee of community members should review and prioritize submission based on their understanding of the needs of the community.

Stakeholders can also play a supportive role. As part of the goals process, several organizations have signed a pledge to work toward common goals. These organizations may be a resource to the organizations and individuals seeking support through the Collaborative. Organizations signing the pledge can offer their own form of support alongside the support given by the Collaborative. This network of pledgees can be drawn upon as partners to enhance and expand innovations across the state.

Barriers to Innovation in the State

The Innovation Committee identified the following potential barriers which limit the impact of innovations to improve health in Utah. The Collaborative should be cognizant of these barriers as they may limit the reach of innovations supported by the Collaborative, and because the Collaborative can play a role in overcoming these barriers.[1]

- **Historical context of policy and decision-making.** Are decision makers focused on health and access to care for all, especially those most vulnerable and representing the minority, and sometimes dissonant, culture? What limitations exist because of status quo bias?
- **Belief that all innovation must be creating something new.** There are examples across our state and the country of effective transformation of healthcare delivery, community organizations, and payers from transactional health care to whole person health orientation. These should be assessed and amplified where appropriate.
- **Lack of capabilities to assess, amplify, and scale innovation.** Some organizations managing innovative programs and interventions lack the capacity to assess, amplify, and scale their programs, or lack the bandwidth or expertise to design an implementation and development plan. It will be critical the Collaborative include talents to leverage innovation.
- **Coordination among necessary stakeholders.** There needs to be an expectation of collaboration and compromise to bring innovation to fruition. If stakeholders are not willing to give something up for overall better community health, innovation cannot be achieved. The Collaborative could relieve pressure and allow stakeholders to identify and scale ideas to lower costs and increase quality of care.
- **Federal limitations.** The federal limitations on plan design, or perceptions of regulatory constraints, can restrict the ability of the state or private sector to implement reforms (e.g., ERISA for employer sponsored plans, ACA, Medicaid).
- **Benefit design.** Changing benefit design to incorporate coverage for non-traditional services or to reimburse for services in non-traditional ways can be

[1] Several barriers to achieving better health outcomes in the state were also identified during the design process – these can be found in *Appendix A: Ideas for Future Innovations*

difficult when stakeholders in charge of design are stuck in old-style models and restricted to achieving profitability on a 12-month budget.

- **Reform often increases administrative costs.** Reforms made with the intention of improving the system and patients' health often wind up increasing administrative costs. One participant described many of these reforms as "kludgy add-ons." Even if the reforms have positive outcomes on patient health, it can be difficult to incentivize participants to join in on these reforms if they recognize how much administrative work will be required.
- **Lack of a safe forum for people to share and convene ideas.** A key barrier to developing and sustaining innovative healthcare programs is the lack of collaboration on solutions in a competitive market environment. Healthcare is a "big business" in the United States (accounting for 19% of GDP (compared to 12% of GDP or less in other developed countries). Effective reform will likely reduce revenue for many stakeholders, both through the reduction of waste and the implementation of better models, processes, and technology. The collaborative should foster an environment where stakeholders can come together to socialize ideas that will create value (improve access and outcomes, while reducing total cost) across the healthcare ecosystem, understanding that some key stakeholders will see reduced revenue or a drastically altered business model.
- **Costs and risk of switching to new business models.** Switching to innovative healthcare plans and programs can be costly for employers. Transitioning to upside and downside value payment for providers also creates new revenue streams risks in the time between volume and value.
- **Siloed reform efforts.** Referring partners can often help each other to offset costs.
- **Lack of interoperability.** We do not have a central record, repository, or framework for sharing patient data in real-time.
- **Lack of transparency.** There is no central tool or system to search for the usual and customary pricing of services rendered by providers.
- **The diversity of programs that payers and providers have in place.** Providers must work with many different sets of quality measures and goals from payers, and vice versa. This is a barrier that the Collaborative could address by working with payers/providers to set some common measures/goals.
- **Lack of access/capacity.** For example, because we have limited access to behavioral health In Utah, innovations that would succeed with sufficient behavioral health access may fail.
- **Payers and providers are rooted in fee-for-service.** Fee-for-service payment models limit the ability of payers and providers to address the holistic needs of patients, implement innovative programs, and keep healthcare transactional.
- **Consistent health outcomes views by equity lens for all measures are not available.**

Process for Identifying Innovations to Support
The flowchart depicted below illustrates the process the Innovation Committee is recommending the Collaborative adopt to deploy support to innovations across the state. Each element in the flowchart is described in greater detail in the subsequent sections.

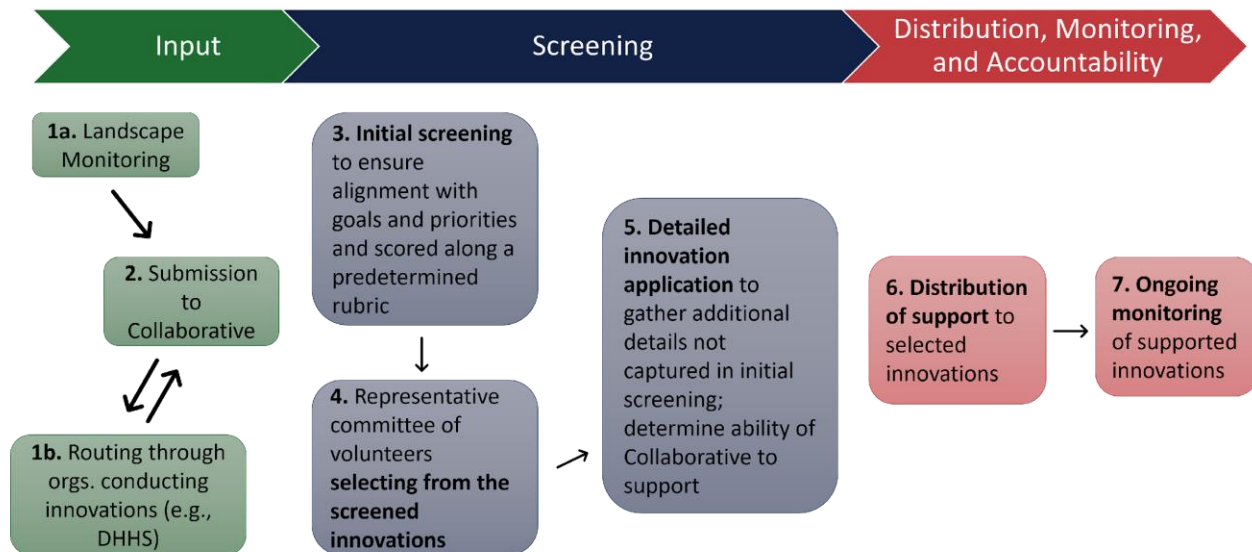


Figure 1: Innovation Support Flowchart

When designing the process for identifying innovations that the Collaborative will support through promotion, partnership development, grant funding, or other means, the Executive Director and team should keep in mind the following recommendations. Recommendations in this section apply primarily to the Input and Screening portions of the Innovation Support Flowchart, items 1 – 5.

- **Create a diverse board/committee/group of volunteers to support the identification and selection of projects.** This group of community members can use their connections with local stakeholders to identify existing programs the Collaborative may be interested in (item 1a of the *Innovation Support Flowchart*), help get the word out about the Collaborative so individuals know they can seek support (item 1b of the *Innovation Support Flowchart*), and be an unbiased body to help narrow down the innovations the Collaborative should prioritize to provide services and/or funding (item 4 of the Innovation Support Flowchart).
    - Existing community groups can play a role in facilitating the buildout of this new group. The Utah Association of Community Health Workers has expressed an interest and availability in playing this role.
    - Special attention should be given to ensure the group represents a diversity of stakeholders and can be neutral.
    - It is important to recognize the importance of compensating this group for their time.

- **Engage in monitoring the state landscape to identify programs in need of support**, as highlighted in item 1a of the *Innovation Support Flowchart.* For example, organizations that received funding through the American Rescue Plan Act during the Public Health Emergency may have initiated innovations that are now in need of additional funding and could benefit from the services of the Collaborative. Additionally, this process could include listening tours and focus groups.
- **Make available and promote a function for individuals to seek support for their innovations.** The Collaborative should allow organizations to submit applications to seek support from the Collaborative, as illustrated in item 2 of the *Innovation Support Flowchart.* The Collaborative should make communities aware of this portal using the board of volunteers previously highlighted or by connecting with entities that operate like the in-development Utah Department of Health and Human Services Customer Service Department, which is explicitly designed to be a portal to redirect information to its intended recipient. The Collaborative should ensure that public and private entities are aware of the location of the submission portal and can share it with their networks.
    - Ensure the portal is accessible to a diversity of applicants. The support provided by the Collaborative should be made available to all innovations, particularly those that have been overlooked by other options in the past. To do this, ensure the portal through which support is requested is accessible in a variety of forms, including in several languages and offline (e.g., via a phone call interview or paper form).
- **Design a process to screen submitted innovations for eligibility.** Innovations submitted through the submission portal should undergo screening to determine whether they are eligible to receive support from the Collaborative (the process represented in item 3 of the *Innovation Support Flowchart*). This initial screening should evaluate innovations based on how well they reflect the goals and priorities of the Collaborative. They may also be evaluated based on other criteria, feasibility, scalability, impact, measurability, and other items determined to be important by the Collaborative. The Collaborative should design a rubric or other scoring mechanism to objectively evaluate innovations. Once the pool of submitted innovations has been narrowed, a representative committee of volunteers can decide which innovations move on to the next step and fill out a more detailed application for support, the process highlighted in item 4 of the *Innovation Support Flowchart*. The more detailed application gives applicants an opportunity to share data related to their innovation and select the type of support they are seeking from a menu of options (the types of support the Collaborative could offer is outlined in *Strategies for Supporting Innovations*. **When prioritizing which innovations to support, the Collaborative should consider the following:**
    - **Prioritize innovations with the ability to scale.** Innovations that other organizations can relatively easily adopt and scale (e.g., the Psychiatric

Consult Collaborative Care Management Model, created by the University of Washington, was able to be adopted by the University of Utah) should be chosen over other innovations.

- **Consider impact across stakeholders.** It is critical to consider how innovation will impact all stakeholders (e.g., government, payers, providers, patients, and employers). Specifically, the Collaborative needs to focus on innovations that improve and maximize value across as many stakeholders as possible. Otherwise, it will be difficult to break the barriers necessary to create substantial change across the system. Some proposed innovations might single handedly create value across multiple stakeholders, but in other cases multiple ideas might collectively create value across multiple stakeholders. The Collaborative needs to focus on innovations that have a force multiplier effect.
- **Financial performance is not the only important outcome**. While innovations should be held to some performance metrics, financial performance should be considered in addition to other outcomes. The Collaborative should keep in mind that important innovations may improve outcomes but not reduce costs in the short term.
- **Consider innovations that could be piloted in Medicaid, state employees, or other populations where the Collaborative might have more direct ability to influence adoption.** These are areas that can be influenced by the governor and state budget process, provided they are in scope of federal and state regulations and policy. 1115 waivers are one avenue for implementing innovation in the Medicaid program and can be informed by actions in other states.
- **Topics of focus.** The Collaborative should prioritize supporting initiatives focused on: addressing disparities in access and health outcomes; bringing health care to rural communities; leveraging community (lay) workforce to advance health; strengthening and training workforce in community and healthcare settings to advance health; and digitally enabling health and healthcare especially with vulnerable populations.

Strategies for Supporting Innovations

A primary role of the Collaborative is to support innovations already happening in the state. The prior section describes how the Collaborative can choose which innovations to support among the many ongoing programs. This section describes the several types of support the Collaborative could offer to those chosen innovations, beginning with non-financial support (e.g., services, advice, technical assistance) and following with financial support (e.g., grants, seed money, etc.). Innovations seeking support can indicate which of these services they would most benefit from during the application process (item 5 of *Innovation Support Flowchart*), then services will be distributed (item 6 of *Innovation Support Flowchart*)

<u>Non-Financial Support</u>
When determining what the Collaborative should do to help enhance and expand innovations in the state, the Executive Director and team should consider offering the following forms of support:

- **Facilitate connections between stakeholders.** There are a myriad of innovations already happening across the state and sometimes the only thing a program needs to expand is connection to a new organization, sustainable funding streams, policy makers, or a new source for clients or members. These stakeholders might be providers, patients, payers, or employers. The silos that exist in healthcare can make it difficult for innovations to cross-pollinate, even within a single organization. It also contributes to redundancy, with several different organizations or departments working to provide similar services to the same group of people without coordination. The Collaborative should consider ways in which to break down these silos and foster connections, including hosting stakeholder roundtables and identifying barriers to breaking down work silos. **While building connections among stakeholders, keep the following in mind:**
    - **The Collaborative can play a role in public policy, but it must be mindful of appropriateness.** Policy advocacy should be avoided in order to maintain the position of the Collaborative as a neutral facilitator. However, the Collaborative may play a role in making connections between innovators and decision makers, disseminating innovations that have been screened, and educating policy makers on barriers and potential paths forward. When considering cases where the policy pathway does not allow funds to flow directly from the state through existing programs (e.g., Medicaid), the Collaborative can play a role in providing proof of concept for potential policy change.
- **Publicity and marketing services.** This might include press releases and spotlight pieces on innovations, case studies on successful programs, and callouts from the governor. This work can provide an avenue for others to replicate innovative work – not just highlighting the work and connecting interested parties but sharing the steps for the work to be replicated by another organization. These publicity services can also help to reduce duplicity that often exists in innovative health efforts between various stakeholders. **When supporting innovations through publicity and marketing, keep in mind the following:**
    - **Aligning messages across organizations.** In order for a message to "stick" with consumers, they must hear the same thing several times. The Collaborative would do well to ensure language and messaging related to various innovations or aspects of the healthcare system is consistent to reduce confusion among patients.
    - **Build community and provider education/buy-in.** The Collaborative can use this promotion mechanism to build buy-in for both the Collaborative

itself and for the innovations it supports. By promoting ongoing innovations, the Collaborative can encourage the development of additional innovations across the state.
    - **Lean on the expertise of local board members and local leaders.** The Collaborative should ask questions to local board members or organizational leaders to find methods to promote innovations that will be most relevant and helpful for them.
    - **Target a variety of channels**. To educate, promote ideas, and gather feedback, the Collaborative should focus on several channels of dissemination, including forums with stakeholder groups (e.g., payers, providers, and employers), townhalls with individuals (across geographies, social/ethnic groups), etc.
    - **Share what matters.** All actions (large and small) should be shared through multiple channels emphasizing: 1) what is the problem being solved, 2) who is involved (how stakeholders identified), 3) what brings them to the table, 4) what compromises were achieved, 5) what multiplier effects were seen (i.e., sum larger than its parts), 6) what barriers were seen and overcome, and 7) results (including process-oriented in shorter/medium term and longer view impact on health outcomes and cost savings). The promotion of innovation will be amplified if the Collaborative is a known entity to stakeholders involved in this work across the state
    - **Collect input from across geographies.** The Collaborative should conduct visits to different geographies across the state to listen and learn. Some work will only emerge through asking for people to share.
    - **Hosting meetings to share ideas.** Hosting a learning collaborative or conference to share ideas and build collaboration across the state could be beneficial to the efforts of the Collaborative.
- **Grant funding expertise.** Consider providing support to help organizations identify and apply for grants for which they may be eligible.
- **Project management and strategic planning services.** Help small organizations scale their programs by providing or supporting developing of project management plans, business plans, and strategic plans to optimize the resources they have and plan for the future.
- **Policy guidance.** While the Collaborative may choose not to engage in advocacy, it can help innovators navigate the existing policy landscape by providing guidance on how current regulations impact their work.
- **Conduct or otherwise enable program evaluation**. The Collaborative should decide the role it will play in program evaluation. Will it directly enable innovations through the provision of third-party assessment of work or will it just simply review evaluations to ensure standards are being met? As part of the application process, the Collaborative can review the feasibility of evaluation

plans (e.g., can the data be collected, is the right data being collected, is the outcome of interest being measured?).

- **Bring together partners from organizations committed to the Collaborative and those seeking support**. Organizations (e.g., payers, providers, employers) can help the efforts of the Collaborative by committing to being a pilot customer for a set number of years, providing innovators with a willing partner for implementing and scaling innovations. As part of the application process, the Collaborative can find natural affinities between committed partners and innovators.

Financial Support

When determining what the Collaborative should do to help enhance and expand innovations in the state, the Executive Director and team should keep in mind the following:

- **Fund innovation but acknowledge the role failure plays in the overall success of this work.** In order to produce the paradigm shift needed to change healthcare, the state will need to dedicate funds to innovate pilots and programs. These funds cannot be contingent upon the ultimate success of every initiative as inevitably, some or many will be unsuccessful. However, attempting something new can create value regardless of its outcome because of the lessons learned. These failures should be communicated rather than hidden.
- **Consider the approach to ongoing versus renewable funding.** The Innovation Committee discussed the need to determine how funding is split between ongoing and new innovations. While this decision has not been made, the Committee discussed several considerations for this process. Innovators should not expect guaranteed renewal each year and should have to show some demonstration of success, whether financial or not, and the ability to compete against new innovations. The Collaborative should keep in mind the dynamic at play where renewing innovations may have more data to prove return on investment (ROI) than new innovations, and while this metric is important, should not prevent new innovations from being funded.
- **When evaluating success, recognize the limitations of expecting a 12-month ROI.** An innovation may not show success, as determined by a traditional ROI, on this time frame. ROI can be measured across several years to see immediate and long-term ROI. Beyond the timeframe, the Collaborative should also consider the diversity of metrics by which to measure ROI (e.g., savings, revenue targets, profitability) and where that ROI accrues (e.g., health system, state, patients). The more stakeholders that accrue value from the innovation, the more likely it is to be sustained into the future.
- **Financial support must come with accountability.** Funded innovations, both new and renewing, should demonstrate a plan to assume operational sustainability without Collaborative support as a prerequisite for funding. This could also be incentivized through providing matching dollars (i.e., funding contingent on matching private dollars brought to the table) or by providing funding that phases

out over time. However, the Collaborative should be careful to ensure that incentives like these do not completely exclude applicants; these strategies should be just one metric of the funding determination.

- **Evaluate innovations to maintain accountability.** It is critical to the success and longevity of the Collaborative, that it has the ability to measure the status and outcomes/results of the initiatives that it undertakes or funds. These should be summarized, at an executive level through data visualization, in a simple dashboard that can be shared regularly with governing bodies (the board for the Collaborative, other stakeholders, the governor, etc.) to track the status of the performance of the various innovations being funded by the Collaborative. Innovations that implement a robust plan to evaluate confounding factors (e.g., running innovation as a randomized control trial) should receive higher priority.
- **Consider the bounds for the types of programs that will be eligible for funding but avoid the rigidity that may prevent truly innovative solutions from being included.** The Innovation Committee discussed several items that could be eligible for funding, including staff, analytic capabilities, and capital investments related to the innovation, as well as what might be excluded, like clinical services already covered by insurance. The Committee cautioned, though, that some flexibility on what is included and excluded should be allowed to avoid preventing the types of innovations that may not have been anticipated from being included, though there was consensus on leaving workforce pipeline innovations outside of the scope.
- **Consider the requirements a program needs to show to be eligible for a grant.** For example, determine whether programs must already have a proof of concept, or if de novo projects will be considered. Also consider whether programs must have specific existing partners (e.g., a payer involved in order to provide ongoing funding), or existing clientele, or if the Collaborative can help provide these connections for grantees. The Collaborative should determine how far outside the realm of traditional healthcare it would like to venture when funding innovations – should it focus its funds on healthcare delivery or upstream innovations? Should the portfolio of innovations funded by the Collaborative be split between those focused on traditional care delivery and those focused on more upstream issues?
- **Start big changes with small pilots.** Think big, act small, and fail fast. It is important that the Collaborative considers big thoughts, pilot them by breaking them down into smaller projects with outcomes that can be evaluated and have the discipline to fail fast when a project does not produce the desired outcomes (or when the hypothesis is disproven) so resources can be reallocated to other initiatives. Dumping resources into a single or a few big innovations is fraught with complications and lowers the odds of success that comes with spreading funding out across multiple areas. The Collaborative should be transparent about its intentions when it comes to the number of projects funded and how much funding is available.

- **Ensure the Collaborative is not primarily seen as the funder of partnerships.** For sustainability, the work must matter to those who engage; they need 'skin' in the game and the Collaborative can bring project management/facilitation skills to connect the stakeholders and maintain forward momentum.

Resources to Support Innovation

Staffing

Based on the recommendations made by the Innovation Committee, the Executive Director and team should consider hiring individuals with the following expertise or background to support this work:

Role	Qualifications	Job Responsibilities
Community Liaison	Individual with experience (ideally five years of experience) in communications and marketing. Preference for applicants with experience in healthcare, particularly with innovative payment and delivery models.	Communicate innovation and One Utah initiative to healthcare entities/providers/community. • Facilitate community dialogue to help identify innovation • Monitor the landscape of innovation in Utah • Manage social media presence of the Collaborative • Organize the annual conference/gathering of the Collaborative • In conjunction with the Executive Director and other team members, support the development and distribution of an annual report • Communicate/report buy-in *[Some of the responsibilities of this role*

		could also be taken on by a marketing firm]
Innovations Manager	Individual with project management experience and experience with organizational operations, particularly in continuous improvement. Healthcare experience, especially related to policy and payment models is preferable. Grant writing experience also desired.	Oversees the operational aspects of innovation at the Collaborative. • Reports to the Executive Director • Interface with the public • Oversee IT, finances, and personnel related to innovation at the Collaborative

<u>Outside Contracting/Resources</u>
The Committee discussed several competencies that will be important to the success of the Collaborative that may be found in either hired personnel or outsourced. These competencies include[2]:

Function	Description of Requirements
Financial management, including grant oversight	Ability to oversee the distribution of grants to organizations across the state and to monitor the progress of work completed under these grants
Grant writing	Ability to identify funding resources and support organizations in application to grants provided by entities other than the Collaborative
Project plan and strategic plan building	Ability to build project plans, strategic plans, and other important business plans in collaboration with organizations who apply for support from the Collaborative
Policy and legal expertise	Ability to advise organizations seeking support from the Collaborative on specific state and local policy questions and help organizations understand how to best accomplish their end goals within the current policy landscape
Evaluation plan building and advising	Ability to review organizations' program evaluation plans and make recommendations for how to improve them, or to build these plans from scratch

[2] In addition to the innovation-specific competencies and functions outlined here, the Innovation Committee recommends that the Collaborative build out its general corporate functions (e.g., HR, administrative support, accounting, legal, IT) to oversee operation of the full Collaborative

IT management of submission portal	Ability to build and maintain an online portal through which organizations can submit requests for support
Customer/innovator relationship management	Ability to track and manage the relationships built between the Collaborative and the organizations it is supporting and building partnerships with

In addition to these competencies, the Committee also discussed the following elements related to staffing and resources:

- **Clarifying the role of the Executive Director as it relates to innovation.** In some small organizations, the Executive Director takes on responsibility for a number of the items the Committee has recommended the Innovations Manager oversee. The division of responsibility between the Executive Director and Innovations Manager should be made clear to avoid confusion and redundancy.
- **Prioritizing equity across positions in the Collaborative.** The Committee emphasized the importance of equity across the Collaborative. For instance, if the data functions of the Collaborative will be overseen by a Data Manager, their salary should be comparable to that of the Innovations Manager.
- **Considering diversity and inclusion when filling roles**. The makeup of the staff at the Collaborative should reflect the diversity of the communities the Collaborative is supporting.

Ideas for Future Innovations

Improving Healthcare Comprehension

- **Starting a public or private health literacy media campaign.** One stakeholder suggested selecting five common health literacy issues that could be communicated to people around the state. Another stakeholder from Silicon Slopes offered that they would be able to help produce something like this via a video or podcast series. Educational efforts that help people live healthy lifestyles and improve their nutrition was a specific topic for a potential media campaign.
    - **Improve patient health literacy.** The healthcare community knows that prevention is cheaper than a cure. There is a large population of Utahns with low health literacy levels, which makes prevention more difficult. Increasing health literacy around both personal health behaviors and health system navigation can lead to more effective care. One Council member noted that issues of health literacy are of particular concern for Utah's refugee population. The Committee may look to organizations, like the Coalition for Health Literacy, for guidance on this subject.
- **Proactive communication from payers to providers and patients.** Payers, along with providers, have a role in ensuring patients are getting the right care in the right setting at the right time. Payers can enable providers in this transformation with timely data and billing assistance. Payers can also engage with their members to promote health literacy to drive these same behaviors.

- **Create a centralized location for health resource information.** One forum participant suggested it would be helpful to have a digital repository of resources, giving community members a single location to find community clinics, available programs, insurance, preventive exams, etc. The Innovation Committee, in conjunction with the Data Committee, might consider how to facilitate the creation of this resource.
- **Personal Empowerment.** Health(care) is often something done *to* people, which can create some disempowerment or expectation that a provider/payer will 'fix' an issue

Public and Private Health Insurance

- **Improve Medicaid enrollment and services.** Throughout the forum, several stakeholders shared ideas for improving Medicaid. One stakeholder suggested that options for Medicaid enrollment and primary care benefits be expanded, and that the Medicaid application be improved to reduce confusion and ease enrollment. Another suggested that savings from Medicaid, or Medicaid funding, be used to subsidize affordable housing for enrollees. Lastly, numerous stakeholders made recommendations for improving Medicaid and CHIP enrollment among children, including doing enrollment outreach in schools and using funds to help market eligibility for Medicaid and CHIP.
- **Reduce the rate of uninsured and underinsured in ethnic minority communities, especially the Hispanic community.** The rates of uninsured and underinsured are higher in the Hispanic community than in the general population. Innovative approaches to ensuring this population should be sought out.
- **Managed high-risk pools.** One idea was to take our most high-risk employees and patients and put them into a risk pool that was separately managed by the state or a collaborative employer partnership. Persons in this pool would be assigned a care management team to help manage their risks and close gaps in care.
- **Broaden Medicaid beneficiary access to providers.** Medicaid beneficiaries are assigned to providers based on their ZIP Code – the assigned provider may not be the best fit if cultural preferences are considered. Medicaid beneficiary assignments might include more factors than are currently being used. This broadening should also consider where providers are not accepting new Medicaid patients.
- **Focus on preventive care.** Stakeholders highlighted several priorities related to improving preventive care in the state, including adopting protocols related to nutrition and physical fitness and increasing the number of Utahns receiving screenings like mammograms and colonoscopies. One attendee reminded the group of the importance of meeting patients where they are rather than dismissing the ways they cope, as well as recognizing the barriers they face to accessing healthy food and recreation. The expansion of federal nutrition programs was highlighted as a strategy to help improve access to healthy food,

and a program like Park Rx was cited as a strategy to improve access to physical activity. One idea revolved around a city or state-wide day focused on preventive health. It could include a festival with a 5k and booths with dieticians, blood pressure checks, etc.

- **Make it easier for small employers and independent contractors to create group plans.** Larger plans benefit from economies of scale—a larger risk pool and more purchasing power enable better insurance design. Small employers and independent contractors have a difficult time enrolling in insurance as a group. One forum participant representing a large association of employers and employees has faced barriers when working with carriers to create group plans that bring smaller groups and individuals together. Removing unnecessary rules and regulations can streamline this process and ensure good coverage for these Utahns. In a state with significant small business and independent contractor representation, this reform could have a large impact.
- **Decreasing regulatory barriers for employers starting health and wellness campaigns.** One employer mentioned that employers starting health and wellness campaigns to improve the health of their employees face administrative burden. Addressing and decreasing regulatory barriers could lighten this burden and help employers implement programs for their employees. One stakeholder suggested that a way to increase the uptake of healthy habits and wellness program participation may center around providing incentives for employees to participate in such programs.
- **Innovative tax models.** One community member suggested a model that would allow taxpayers to use their tax money deductions to opt into coverage similar to Medicaid, as a replacement for higher insurance premiums.
- **Improve patient accessibility.** Measures of accessibility often refer only to insurance coverage. A broader definition that includes other measures like time of access and geographic access can inform Collaborative efforts. Language accessibility and healthcare literacy is another dimension of note. Innovations targeting this broader definition of access would be useful to include in the broader portfolio of innovations.
- **Complexity of plan design and purchasing power.** The complexity of plan design often makes it difficult for patients to understand the avenue through which their dollar is most efficiently spent. In some cases, as one forum participant described, paying cash can be cheaper than paying through a plan, especially for patients covered by high-deductible plans. In many other cases though, going through the payer leads to more purchasing power than going it alone. Finding innovative payers who can help to navigate members through these situations would be worth looking into for innovative approaches.

Preventive and Primary Care

- **Incentivize greater use of primary care providers and address primary care shortage.** Making greater investments into primary care has shown to improve

outcomes; however, as noted by one attendee, the current incentives may not align with the provision of primary care. What we pay and how we pay may require changing in order to improve the adoption and use of effective primary care. The Committee should consider innovations that enable this transformation. Forum participants discussed the barriers that are established by having a comparatively low number of primary care physicians in Utah. While long-term solutions should include simply training more providers, innovative short-term solutions that help to mitigate the consequences of this shortage would be useful to pursue.

- **Address insurance eligibility.** The state currently suffers from one of the highest rates of eligible individuals who are not enrolled in health insurance. One stakeholder noted that while this is a problem throughout the state, it is particularly salient for underserved communities. Initiatives should include helping individuals become eligible for insurance and aiding them in navigating that process. Reducing administrative burden for applying patients is a critical step.
- **Group visits with a coordinated care team for persons with similar chronic illnesses.** One stakeholder mentioned that a solution to the inability to get primary care and preventive care in a timely manner is to schedule groups of persons with similar chronic conditions with a care team that can address the full needs of every person. This would allow persons with these complex needs to receive necessary hands-on care, while allowing providers to receive a manageable volume of patients.
- **Expanding basic care.** A stakeholder suggested Fast Track care options or mobile units dispersed in neighborhoods with increased care needs to prevent slow processes and high costs from emergency department visits.
- **Care for new patients more quickly.** Forum participants noted that wait times for new patients can be longer than for existing patients. Ways in which to reduce the wait for care, including virtual care and mobile clinics, should be considered. Finding these options presents a natural place for the Committee to get involved.
- **Utilize the library.** Forum participants discussed the roles community libraries can play in healthcare, including providing translation services, technology for telehealth access, and improving health literacy. The Innovation Committee might look to local libraries to see if any of this type of work is already being done.

Technology in Healthcare

- **Leveraging virtual care to increase access and lower costs.** One community member highlighted that another solution to the inability to get primary care and preventative care in a timely manner is to increase access to virtual care. They suggested leveraging learnings from the pandemic.
- **Promote interoperability.** One community member highlighted the opportunity the Collaborative has in addressing the long-standing obstacles facing

interoperability. The lack of effective communication between providers, payers, and patients leads to wasteful care. One panelist noted that as the way we deliver care changes, the need for interoperability only becomes more apparent. The Committee should consider innovations that encourage interoperability between providers and organizations.
- **Patient portal for all providers.** With multiple stakeholders citing issues with data interoperability, one idea suggested by a community member centered around creating a patient portal that would aggregate data across providers. This would allow patients to better understand the care they are receiving and properly manage their care themselves.
- **Workforce development.** Stakeholders made two suggestions for improving the healthcare workforce in the state. One recommended that healthcare workers, including nursing students, be eligible for loan repayment programs. Another proposed using medical students to staff community services programs, better preparing students for practice, and expanding the providers available at the community level.
- **Improve access to telehealth services.** One stakeholder pointed out that while telehealth is a great resource to expand access to healthcare for people with transportation or time restrictions, many low-income patients worry that using telehealth services will use all the data on their cell plan. Innovations could focus on using insurance or other funds to help increase the data available for these individuals.
- **Reduce points at which a patient might walk away from care when there is a wait.** This could include proactive rescheduling when appointments are not available (e.g., asking reception to offer placement on a cancellation or waiting list upfront), offering an option to see a PA or someone else in the office first and giving instructions a patient can follow in the meantime, and making referrals easier to get. This is only a sampling of ways this goal could be achieved; the Committee may look to other methods of achieving these outcomes.

Workforce Development
- **Increase the number of professional medical staff.** One stakeholder suggested a statewide effort spearheaded by the Collaborative to incentivize more primary care doctors to come to Utah in order to decrease wait times for primary care services. They added that getting Utahns who have studied medicine elsewhere back to Utah should be a priority for the Collaborative.
- **Reduce training barriers.** One community member spotlighted the need to train clinicians to be more collaborative. Those providing care in the state may not be effectively tapping into the experience and background of other caregivers because they have not been trained to do so. The member also noted how clinical hierarchies have the potential to silence innovative problem-solving. Finding an organization that has effectively reduced or dismantled these barriers would be an important highlight for the Committee to make.

- **Diversify the healthcare workforce.** Finding innovative ways to increase the representation of the Hispanic community in healthcare, and enabling culturally appropriate care, could help to improve outcomes.
- **Leveraging community health workers (CHWs).** Two attendees highlighted the benefits of using CHWs to help support community members. One shared a program that used CHWs to staff healthy living communities where community members came together to walk, run, and be social. Another shared a program that used CHWs to care for patients with diabetes, ultimately reducing their patients' A1c levels.

Social Determinants of Health

- **Health equity.** Rather than having people external to a community develop programs and implement them, design programs with the populations they intend to serve and allow the community to own the program.
- **Healthcare is not equally available to all.** Coverage does not equal access; even those with health coverage have difficulty accessing care. For instance, provider shortages, particularly of specialty, behavioral health, and rural providers, make it difficult for some patients to get timely care. Additionally, underserved groups face further barriers to accessing care, including distrust stemming from historical and modern abuse, language barriers, health literacy barriers, and a lack of culturally appropriate care.
- **Affordable housing.** Section 8 housing is a tool used to help support monthly rent payments, but this subsidy is limited and there are still many individuals not able to access affordable housing. Some states, according to one stakeholder, have found success using Medicaid savings to subsidize housing for very sick individuals.
- **Use the built environment.** To help facilitate preventive care, one stakeholder recommended that communities focus on improving the built environment by adding more green space, walking trails, and bike paths. Another highlighted Get Healthy Utah's Utah Community Designation, which rewards communities for doing things that encourage healthy behaviors.

Behavioral Health

- **Integrate physical and mental healthcare systems.** By integrating the systems, we use to care for physical health and mental health, and better incorporating community-based organizations, Utah could lower costs, improve outcomes, and foster equity, according to several stakeholders.
- **Conduct outreach through schools.** One participant suggested conducting early outreach in schools targeting health behaviors. Innovative approaches here would be a useful inclusion.
- **Improve mental health care.** One Council member expressed concern that emergency departments are becoming holding rooms for patients needing inpatient care. These patients are not best served in an ED setting and take up

resources that could otherwise go to patients needing emergency services. The Committee may look to organizations, like USARA, that can play a role here.

Healthcare Costs and Pricing

- **Move to value-based care.** Multiple forum participants discussed how aligning incentives is at the core of value-based care and health care system transformation. A healthcare system that aligns incentives towards patient health outcomes and cost efficiency is where the system needs to be. This need is well-understood and efforts towards this end state have been and continue to be pursued. Understanding the end goal is helpful, but a path to achieve it is necessary. Steps to build this path might include looking to lessons from Medicaid Managed Care Organizations who have held costs down compared to fee-for-service Medicaid. Additional steps for payers might include improvements to member navigational experience, using data to drive plan design and provider reimbursements, designing plans that align provider and patient incentives and are built on wellness and preventative care, and encouraging consistent billing practices across payers. The Innovation Committee could look to actors who can speak to these suggestions. One participant described the concern expressed by providers when attempting to put together a value-based care plan where performance and financial outcomes rely, in part, on patient behavior to inform financial outcomes. Insurance design and plan benefits are used to drive these changes, but there may be other innovative approaches the Committee could highlight.
- **Collaborative employer program.** One community member said that engaging multiple large employers in the state in an innovative, value-based program would be an exciting opportunity. Not only would this get a critical mass of lives to try something innovative, but employers could use their collective weight to drive meaningful change.
- **Understanding the true cost of care.** It is unclear how much healthcare truly costs. Claims are submitted to payers, providers set some prices, and patients pay a portion, but the true cost and entities responsible for the cost is not clear. Effort should be made to better understand this.
- **Make pricing transparent and predictable.** The inaccessible costs of healthcare came up frequently throughout the forum, but in addition to this, some stakeholders highlighted how difficult it is for patients to even know what costs to expect when they see a doctor. Stakeholders felt that if pricing were more transparent (e.g., if providers and hospitals were required to list their prices for all services) that patients could shop around for services and competition would be introduced to the market, possibly lowering costs.
- **Simplify billing processes.** The billing process is often difficult to navigate for patients; bills for a single visit may arrive from multiple providers and organizations. The Committee may look to organizations already working on ways to improve this process.

Regulatory Changes

- **Reduce administrative burden.** A community member highlighted how the COVID-19 pandemic demonstrated the speed with which healthcare can change and adapt both its clinical and administrative processes. Areas for potential change the Committee may look to include credentialing, licensing, payment, and regulatory processes.
- **Enable innovation in the private market.** A successful transformation of healthcare in Utah will require that private actors lead the change. One forum participant expressed concern, echoed by others, around government efforts that address the symptom and not the cause of rising healthcare costs. Another participant, working with employer-sponsored plans, noted that they have been successful in limiting cost increases because they are not subject to many of the regulations that other types of plans are. Ensuring the purpose of the Collaborative remains in a facilitative position for stakeholders is key to achieving success in the Utah way. Bottom-up community solutions could lead to the stakeholder buy-in that ensures lasting change in a way top-down government-driven solutions often cannot.
- **Use the tax filing process to solicit private funding for healthcare services for low-income Utahns.** As part of the tax filing process, Utahns can choose to voluntarily contribute to causes like homelessness, organ transplantation, and clean air. One council member suggested that healthcare services for low-income Utahns could be added to this list. The Innovation Committee may look to push this option and/or connect with the people who can.

Home-Based Care

- **Move outside of traditional care sites.** Mentioned by both attendees and panelists was the need to treat patients at new and non-traditional locations. The pandemic demonstrated that some care, such as the administration of vaccines and preventative care, can effectively be delivered in the home, in the community, and through telemedicine. Additionally, one member put forward the need to move upstream regarding home care. It goes beyond post-acute care and the state should move upstream in its thinking about what home care can accomplish. Utilizing home care more effectively will impact both the affordability and quality concerns this initiative hopes to address. An innovative home care company would be a useful addition to the Committee's innovation portfolio.

Rural Care

- **Address the needs of rural Utahns.** One stakeholder recommended the Collaborative look into Alaska's Nuka System of Care as a potential strategy to improve access to healthcare in rural Utah. This system has successfully brought

healthcare to Alaskans living in remote areas, and lessons learned from this study could be applied in Utah.

Learn Lessons from Diverse Sources

- **The Collaborative should keep current on successful strategies in other states.** Work from the Robert Wood Johnson Foundation, Kaiser Family Foundation, Agency for Healthcare Research and Quality, Center for Medicare and Medicaid Innovation, payers, and other organizations might yield lessons.

APPENDIX D: RECOMMENDATIONS FROM THE COMMITTEE ON DATA

In order to support the development of the One Utah Health Collaborative, the Data Committee has proposed the following series of recommendations. These recommendations are based on information gathered by stakeholder forums conducted with patients, community-based organizations, payers, care delivery representatives, and employers as well as thoughtful discussion between the experts represented on the Data Committee. While developing the business plan for the One Utah Health Collaborative, the Executive Director and team should use these recommendations to guide the Collaborative's strategy related to data-oriented initiatives as well as the collection and analysis of health data.

Data Committee Membership

Selection

Members of the Data Committee were selected from the pool of applications submitted via the state's website, as well as individuals identified as key opinion leaders during an initial landscape assessment. The Data Committee sought out members that represented diverse stakeholders with varied backgrounds and opinions. Members were selected based on their personal perspectives and not necessarily based on their current organization affiliation.

Committee Members

Member	Organization	Role
Chris Klomp	PointClickCare	Committee Chair
Laura Summers	Kem C. Gardner Policy Institute	Committee Co-Chair
Andrew Sorenson	Castell Health	Member
Carl Letamendi	Office of Health Care Statistics	Member
Dan McMaster	3M	Member
Ken Kawamoto	University of Utah	Member
Maia Hightower	Equality AI	Member
Mary Jane Pennington	Granger Medical Clinic	Member
Steve Neeleman	HealthEquity	Member

Scope of the Collaborative's Data Activities

Role of the Collaborative

The effectiveness of the Collaborative will, in part, be predicated upon its ability to deploy data capably across its various initiatives. As a foundational activity, the Collaborative anticipates identifying, supporting, and promoting innovations throughout the state as a means of accelerating progress. This process will require the collection, analysis, and interpretation of data. The Collaborative should thus be well equipped with expertise and technological assets, which will facilitate this exercise of advancing innovations. Those serving data roles within the Collaborative may participate in this process by helping to identify measurements and data sources, proposing tools for the collection and analysis of data, and aiding in outreach.

Additionally, the Collaborative should lead a series of initiatives and activities closely tied with data. Working towards clinical interoperability and establishing and monitoring a baseline measure of health should both be highly prioritized Collaborative-led efforts. These should be pursued irrespective of other activities occurring throughout the Collaborative and will be deeply informed by the data resources of the Collaborative. The Collaborative should deploy data as an arbiter of truth to insulate itself from influences of special interests. The Collaborative's mission and activities may run counter to the goals of some stakeholders at times. Effectively utilizing data to support the efforts of the Collaborative and share how well it is meeting its outcomes will help ensure that resources are appropriately distributed to improve the health of Utah's population.

Role of the Stakeholder Community

Various stakeholders, including employers, patients, payers, providers, government, and the innovation community have a supporting role regarding the Collaborative's data activities. For example, some stakeholders may be asked to contribute data at a level not previously asked of them. This will require greater communication and trust both between stakeholders and the Collaborative as well as among stakeholders themselves. Reciprocity of data exchange, both clinically and in support of measurement (which may include operational and financial data) will be essential to establish and maintain trust and a level playing field across stakeholders. Government likely should not be the central store of this data. In addition to contributing data, stakeholders should effectively use their own data to support and incorporate the data efforts of the Collaborative into their own systems as appropriate.

Stakeholders should always have a strong voice in the activities of the Collaborative, including those related to data. They can do this by surfacing opportunities for change, highlighting challenges, and submitting ideas and innovations that will move the state in a positive direction. Each stakeholder will have a different opportunity to contribute to the Collaborative and each will play an individual role in its success.

Recommended Initiatives Related to Data

Baseline Scorecard

The Collaborative should facilitate the creation of a state and a regional scorecard to create a baseline measure of health and its associated costs. The tool should align with the broad goals of the Collaborative and include metrics in the categories of affordability, outcomes, and equity. The success of such an effort will depend on effectively incorporating and addressing the following:

Implementation Recommendations:

- **State and Regional Reporting** – Metrics must be reported for the entire state as well as for intra-state regional assessment. The Data Committee recommends this occur at the local health district level but would encourage reporting at the county or small area level where possible.
- **Comparison and Benchmarking** – The main purpose of the scorecard should be to create a baseline of health and track changes over time. When possible, the Collaborative should compare the results of the metrics included on the scorecard to the performance of surrounding states and the country broadly. The Collaborative should also consider appropriate benchmarks to identify potential gaps and areas of progress.
- **Highlight Success / Anonymize Low Performance –** State and regional area data included in the scorecard should be easily known and broadly distributed as a means of encouraging improvement. However, those entities within a given region which contribute data to the scorecard should be anonymized. The exception to this anonymity would be for those entities that report noteworthy successes on a given metric or a set of metrics and are willing to share their success. These exceptions should be broadcasted appropriately, lessons learned should be distributed to interested stakeholders, and best practices should be studied and shared.

Important Considerations

- **Risk Adjustment** – While the state of Utah boasts a particularly healthy population, this may be in some part due to its especially young age. Thus, data included in the scorecard should be appropriately adjusted for factors such as age, race, and other elements that may impact a population's health to accurately depict the health of the state. This should be done for all metrics and used when comparing between counties and when comparing Utah with other states.
- **Equity Analysis** – Where possible, the metrics included on any scorecard should be considered and reported across appropriate socio-demographic factors including race, ethnicity, sex, zip code, urban/rural classification, income, and education.
- **Measurement Selection** – The Data Committee has included several potential measurements for inclusion; however, measures should be properly vetted before being incorporated into the scorecard. For example, the Collaborative

should consider the broad acceptance of a given measure by the healthcare community if it desires to compare the state of Utah on said measure with other states. Additionally, the ability to replicate a given measure across the state with a high degree of certainty should be a high priority before including a metric. With this as context, the Data Committee recommends that the Collaborative also consider appropriate metrics for which there is no current accepted method of measurement. For example, while happiness has been included as a measure on reports of health and well-being, it may not have a broadly accepted measurement mechanism though is well-researched and merits consideration for inclusion[3]. Despite this, the Collaborative should consider vetting potential instruments for measuring happiness and including the measure in its scorecards. Other similar measures should be considered, and appropriate screening and statistical analysis should be conducted.

- **Cost/Benefit Tradeoff of Data Acquisition** – Obtaining and tracking the data for each metric on the scorecard will incur varying costs and result in differential benefits. When assessing potential metrics, the Collaborative should consider the feasibility and potential return for the requisite data collection and analysis.

Potential Barriers

- **Data Collection** – Barriers related to data collection may hinder being able to effectively measure improvements in health outcomes over time. The Collaborative should be prepared to face questions and overcome obstacles related to data lags, unavailable data (e.g., data related to the social determinants of health (SDOH)), and data missing for significant portions of the population (e.g., uninsured individuals). These gaps and barriers should not be ignored, and efforts should be made by the Collaborative to create as comprehensive a dataset as possible. That said, it is recommended the proposed scorecards be executed as quickly as possible by the Collaborative with included qualifications about what data is missing and what efforts are being made to address any gaps in future.
- **Stakeholder Disagreement** – The Data Committee anticipates that stakeholders throughout the state will disagree on the metrics included in the scorecard and methodology for collecting data. This extends to the level and method of risk adjustment and potentially the attribution of population to a given entity or region. The Collaborative may encounter pushback, especially by entities or regions that feel they are being misrepresented.
- **Suitable Benchmarking** – If the Collaborative heeds the recommendation of the Data Committee to set benchmarks for the included metrics, it may be difficult to determine a suitable level of attainment. Some benchmarking is well established but may not be applicable to the population at large (e.g., Medicare benchmarks

[3] For example, Happiness is studied and measured through the Oxford Happiness Questionnaire: http://www.blake-group.com/sites/default/files/assessments/Oxford_Happiness_Questionnaire.pdf

may only be applicable to Medicare-eligible populations). The Collaborative should consider adopting similar benchmarking efforts by other states as a possible source of standard setting.
- **Challenges with Risk Adjusting** – Risk adjustment should be applied selectively as to not distort the pragmatic usage of the data. For example, if disputes occur over the outcomes reported on the scorecards, stakeholders may cite potential flaws in the risk adjustment methodologies rather than addressing underlying care gaps. Similarly, risk adjustment has the potential to distort discussions surrounding practical affordability for patients. Additionally, when comparing to other states, the necessary data for risk adjustment may not be available or inadequate for those comparison targets, making non-risk adjusted comparisons the only option.

Governance and Resourcing
- **State-Owned** – The Data Committee recommends that the scorecards be owned by the State of Utah. Specifically, the Office of Health Care Statistics (OHCS) is recommended as the owner given its concurrent work. OHCS would own and maintain the scorecard and be responsible, in conjunction with the Collaborative, for reporting the results and highlighting noteworthy entities. The Kem C. Gardner Policy Institute would be an additional resource that the Collaborative could engage for measurement and reporting expertise.
- **Collaborative-Facilitated** – The Collaborative will play an integral role in helping to develop and define the scorecard, align its purpose with the accepted overarching goals, and communicate results. Additionally, the Collaborative can help facilitate any private resourcing that might be necessary for activities such as risk adjustment, which could require licensing from a third party. Last, the Collaborative can help to marry the public and private interests of entities within the state and surface concerns, ideas, and innovations related to the scorecard. These efforts may require the hiring of at least one senior data analyst with experience in risk adjustment, biomedical informatics, data reporting, and a comfort in dealing with external third-party vendors.
- **Third-Party Enabled** – Creating and maintaining the scorecard may require efforts from private third parties such as entities licensing risk adjustment methodologies, entities that can facilitate benchmarking, and entities with quality measurement expertise. Specific examples might include 3M, Optum, or Change Healthcare for their risk adjustment expertise or 3M for benchmarking services. The Collaborative should allocate necessary funds to engage these partners.

Clinical Interoperability

Moving closer towards the goal of clinical interoperability should be among the chief initiatives for the Collaborative as a whole. Doing so has the potential to reduce unnecessary spending by eliminating redundancies, improve patient care through greater coordination, and empower patients with comprehensive data. While achieving

interoperability requires significant technical, legal, and policy work, the data committee has identified the following priority domains that will be key in accomplishing this objective:

Data Completeness

The goal of interoperability should be similar to the overarching goal of medicine, namely, treating the whole person. Thus, it is recommended that any interoperability efforts the Collaborative engages in consider "whole-person" data as its target. This includes a comprehensive view of all clinical records from all medical providers, including the incorporation of mental and behavioral health information which is currently omitted. Additionally, as interoperability capabilities become more robust, elements related to an individual's SDOH should be adequately incorporated.

- Implementation Recommendations:
    - **Mechanism and Exchange Agreement** – The Collaborative should work to align all stakeholders on an agreed upon mechanism and a broad exchange agreement for the interchange of information. This includes accordance on the modality and timeliness of exchange as to adequately support decision makers utilizing the information.
    - **Standard Format** – The Data Committee recommends that the Collaborative take action to align stakeholders throughout the state to adopt a standardized format for the exchange of information. Work towards this end should take place as early as possible since some data already being exchanged (e.g., Admission, Discharge, Transfer data) still suffers from disparate formatting among stakeholders.
    - **Minimum Appropriate Dataset** – Efforts should be made to align all stakeholders on what constitutes a minimum appropriate dataset. The amount and types of data currently being shared in the state differ from stakeholder to stakeholder. The Collaborative should convene entities throughout the state to inform what would constitute such a dataset.
    - **Incorporate Mental and Behavioral Health** – Greater emphasis must be made by the state and Collaborative to include mental and behavioral health information as part of the whole-person dataset. Doing this may require changing state and federal policy as well as considering what legal provisions will need to be put into place to secure data, which the Data Committee recommends the Collaborative support. Additionally, this data should be similar to other clinical data in that it should default to inclusion with an opt-out possibility for patients wishing to exclude it from any records.

Unique Patient Identification

One of the most difficult aspects of interoperability pertains to the ability to identify unique patients across multiple systems and properly assign their information to them. While interoperability can occur in other shapes and forms without this ability, achieving

a robust system for identifying an individual and accurately assigning their data to them will greatly enhance the interoperability's effectiveness. The Collaborative should consider current efforts being made in the state and across the country and take action to move towards a process for unique patient identification.

- Implementation Recommendations:
  - **Credentialling System** – Key to any effort related to establishing unique patient identification is a trusted credentialling system that allows for data to be driven down to the person. This goes beyond an identifying number and may look similar to the process for obtaining a driver's license. Namely, individuals would have the opportunity to identify themselves, using accepted forms of identification, after which, they are known within the credentialling system and data can be easily assigned.
  - **Non-Participation –** As the credentialing process will require individuals to make themselves known and provide proof of identification; it is anticipated that a non-trivial portion of the population will abstain. This requires that information related to treatment, payment, and operations continue to flow for the entire population to facilitate informed decision making on the behalf of patients.
  - **Technical Assistance Resources –** Due to the technical nature of this process, the Collaborative, in conjunction with the state, should be prepared to provide technical assistance to individuals in need.

Data Access

Even though technical interoperability may be largely achievable, patients and providers continue to face barriers when accessing clinical data. Information frequently lags, making action at the point of care more difficult and often leading to the duplication of care. Data is also entered and accessed across several different platforms, requiring patients and providers to navigate disparate portals and search for information displayed in slightly different manners. The Collaborative should make efforts to streamline this process, empower patients to own their data, and facilitate access to as close to real-time data for providers making decisions.

- Implementation Recommendations:
  - **Centralized Data Source** – Much of the information currently provided to patients is delivered on a particular entity's patient portal. While these are effective and have led to greater patient knowledge, the Collaborative should consider facilitating the creation or use of a central repository for patients to access, which would provide a comprehensive view of their information. This might also be accomplished using a framework (e.g., Apple Health) allowing patients to connect to data from various sites of care for the purpose of aggregating that information personally.
  - **Consent Based Frameworks** – Patients owning their data also implies that they should have the ability to dictate with whom the data is shared. The Collaborative should work towards creating a consent-based data sharing

network where patients have greater ability to determine by whom and how their data is accessed. This will become increasingly important as non-traditional healthcare data becomes more integrated into an individual's health profile. To be clear, this should not supplant the current HIPAA-defined opt-out consent model recognized by the State of Utah for purposes of sharing data for treatment, payment, and healthcare operations as well as for public health reporting (see below *Governance and Resource Considerations* for additional detail).

Other Considerations

- **Measuring Progress –** The Collaborative should place a high priority on making progress towards interoperability and should thus make efforts to measure this progress. This might be included in the scorecard discussed above or could be a separate initiative. Measuring the effort could include survey tools to better understand how those using the data are accessing and deploying it to the benefit of the patient. There may also be the need for more quantitative metrics such as the percent of the population with a minimum viable dataset that is accessible by all providers.
- **Price Transparency –** Some of the work mentioned above to aggregate and give access to data may expedite progress toward greater price transparency as well. The Data Committee recommends the Collaborative consider and prioritize related efforts to create and strengthen price transparency tools and that such information be integrated into the clinical information accessible by patients and providers.

Potential Barriers

- **High Cost –** The costs associated with interoperability are particularly high and may pose an obstacle. Many entities will likely face substantial costs in the form of change management, technical upgrades, and operational refinements. Central support for these costs should be contemplated.
- **Privacy Concerns –** A key concern for many stakeholders interested in interoperability is the potential for intrusion of privacy and possible security breaches. These concerns have recently been heightened as the number and scope of data breaches at healthcare entities have increased.
- **Political Aspects –** Some aspects of meaningful interoperability may require legislative action and the updated legal provisions. Taking such action brings a political element to the interoperability discussion, which may slow progress.

Governance and Resource Considerations

- **Reduce Redundancy –** This is not a specific recommendation for governance; rather, it is a suggestion that all efforts related to interoperability first begin with an assessment of current actions being taken by the state, federal government, and private third parties. The Collaborative should be deliberate about where to

expend resources and whether new initiatives should be developed or whether investments should be made into work already underway. Examples of these include Experian, UHIN, and state efforts to create a single sign on credential.

- **Trusted Third Party –** It would seem unlikely that a state entity could serve as the aggregator of such exhaustive datasets. Other stakeholders, such as provider entities, likely do not have the expertise or bandwidth. It is also unlikely that the Collaborative will be equipped to take on such an undertaking. Thus, a third party will likely need to be engaged to serve as an accumulator of the data.
- **Opt-in vs. Opt-out –** Functional interoperability is only meaningful as data becomes more comprehensive, trustworthy, and deployable. Having as much of the population participating as possible should be a high priority of the Collaborative. Consequentially, whenever possible, data should default to inclusion with the opportunity for individuals to opt-out as they desire. Only in specific instances should the data necessary for interoperability default to an opt-in process. More clearly, all data related to treatment, payment, and operations (TPO) should remain available to relevant parties as per current HIPAA regulations. As noted above, the Data Committee also recommends that this opt-out process be inclusive of mental and behavioral health, which is not currently the default. Specific examples of issues that should be opt-in include instances where patient data is shared with a third-party not serving a TPO function and for those wishing to participate in the unique patient identification process outlined above.
- **Collaborative Resources –** Despite the opportunity for the Collaborative to have an outsized role on the future of interoperability in the state, much of the accompanying work will be done by other entities (see points above). That said the Collaborative will need a particularly strong individual with broad industry and technical expertise in order to understand, lead, and collaborate on projects related to interoperability. The Data Committee recommends that the Collaborative employ an interoperability expert familiar with the current state, an understanding of accepted standards, and policy knowledge.

Facilitating Innovation

Data analysis and evaluation will be an integral part of identifying, assisting, disseminating, and measuring impactful healthcare activities happening throughout the state. The data committee recommends that any process used to evaluate innovation utilize a data framework to assess statewide health gaps, and then identify, validate, and support those innovations.

<u>Proposed Framework:</u>

- **Gap Assessment** –
    - Acquire, prepare, and link health data
    - Evaluate and prioritize actionable gaps
    - Determine focus areas related to the Collaborative's identified goals

- **Validation** –
  - Identify programs and pilots occurring throughout the state
  - Document expected impact and timeline
  - Narrow list of interventions
  - Validate against expectations
  - Finalize list for further Collaborative support
- **Enable & Amplify** –
  - Establish a measure set to validate macro impact
  - Initiate interventions or support
  - Validate impact and modify interventions

Implementation Recommendations:

- **Part of a Larger Framework** – The framework described above is particularly important for the measurement and evaluation of innovations occurring throughout the state but is absent of making any recommendations on how to identify or enable any initiatives. It is only one portion of a larger framework that the Collaborative should construct that incorporates data, evaluation, innovation, goals, and resources to help propagate meaningful change throughout the state. The larger framework should include principles around resource allocation, innovation selection, and the sharing of lessons learned.
- **All Health-Related Innovations** – The Data Committee recommends that this framework be deployed for innovations in both the traditional settings of care as well as the broader settings that affect a given person's health. Thus, the Collaborative might measure and evaluate innovations occurring in community-based organizations as part of its broad efforts.
- **Predicated on Goals** – Important to identifying, evaluating, and supporting innovations is first knowing which innovations will make the most impact for the state. Thus, the Data Committee recommends that any evaluation of innovations be founded in the goals the Collaborative ultimately adopts. These should be used as guiding principles and innovations that will help move the state towards its goals and should be given priority.

Potential Barriers:

- **Resource Limitations** – Effectively evaluating innovations will require more resourcing than traditional data analytics. The Collaborative may need to engage multiple data scientists, analysts, IT roles, and evaluation experts in order to adequately assess identified initiatives.
- **Need to Collect Data** – Some data required to appropriately evaluate a given initiative or innovation may not be readily available to the Collaborative. Sourcing new data or collecting the data can be burdensome and expensive. The Collaborative should be prepared to support primary data collection in specific instances.

- **Perceived Bias** – The endorsement of the Collaborative may be an effective way to generate adoption of an innovation. There is a potential that entities may perceive this endorsement as biased if those innovations receiving support from the Collaborative run counter to a given organization's best interests.

Governance and Resourcing

- **Three Potential Configurations** – The Data Committee does not have a specific recommendation for a particular governance structure for the measurement and evaluation of innovations. However, it has identified three potential configurations with governance and resourcing configurations as well as the benefits and drawbacks of each. These include the following:
    - **Collaborative Owned**
        - Governance
            - Wholly owned by the Collaborative
            - All evaluation and measurement done "in-house"
            - Engage state and private vendors only for specific needs
        - Resourcing
            - Multiple data scientists, informaticists, project managers, IT specialists, and evaluation experts
        - Benefits
            - The Collaborative serves the role of a neutral party to mitigate bias
            - Allows the most control and oversight by the Collaborative
        - Drawbacks
            - Very resource intensive
            - Less flexibility with resources
    - **Hybrid**
        - Governance
            - Owned by the Collaborative with significant portions of the work being handled by third parties
            - The Collaborative would broker solutions and collaborate with healthcare agencies
            - Contract with third parties on a project-by-project basis
            - Examples: California Healthcare Foundation, Oregon Health & Science University
        - Resourcing
            - A team of data scientists and analysts to support and lead a cohort of targeted vendors
            - Payments to third parties
        - Benefits
            - Allows for meaningful representation of the Collaborative in the effort while utilizing the scale and expertise of third parties

- Drawbacks
  - Will require high levels of coordination between multiple entities
- **Outsourced**
  - Governance
    - Measurement and evaluation of innovations will be largely outsourced to private vendors
    - Examples: Artemis Health, 3M
    - The Collaborative will serve a coordinating role to align efforts with agreed upon objectives
  - Resourcing
    - A senior data executive representing the goals of the Collaborative and coordinating efforts across third parties
    - Payments to third parties
  - Benefits
    - Most scalable to meet demand as the number and quality of innovations ebbs and flows
  - Drawbacks
    - Likely the most expensive of the three options

Resources to Support Data Activities

Staffing

Based on the recommendations made by the Data Committee, the Executive Director and team should consider hiring individuals with the following expertise or background to support this work:

Role	Qualifications	Job Responsibilities
Senior Data Analyst	• Strong experience with risk adjustment • Working knowledge of biomedical informatics • Familiar with current data resources throughout the state • Experience working with third party vendors • Able to translate and disseminate data for stakeholders	• Working with state and private entities for the collection and analysis of data • Collaborating with outreach personnel to help interpret and broadcast scorecard results • Primary data analysis
Interoperability Subject Matter Expert	• Familiar with the current state of interoperability	• Create an evaluation framework for assessing the current

	● Understanding of current technical standards ● Policy and legal knowledge ● Technical expertise	state of interoperability in the state ● Conduct an assessment of current state of Utah's interoperability ○ Current Assets ○ Current Gaps ○ Best Practices ● Propose and facilitate an interoperability plan including: ○ Policy and legal recommendations ○ Technology recommendations ● Coordinate execution with public resources or private vendors
Evaluation Framework Personnel	See Governance and Resourcing under "Facilitating the Collaborative"	

Outside Contracting/Resources
Based on the recommendations made by the Data Committee, the Executive Director and team should consider the following additional resources to support this work:

Function	**Description of Requirements**
Benchmarking Partner	The Collaborative will require a partner to help benchmark chosen metrics against performance by various regions within the state, other states, and nationally.
Risk Adjustment Licensing	The Collaborative will need to evaluate and engage a third-party provider of a risk adjustment methodology
Program Measurement Partner	It is most likely that the Collaborative will need to engage a third party for the data collection, assessment, and evaluation of innovations.

APPENDIX E: ONE UTAH HEALTH COLLABORATIVE BYLAWS
This document is currently being revised.

APPENDIX F: DATA DECK
This resource highlights work prepared by the Data Committee of the Organizing Body and outlines key initiatives to drive forward the goals of the One Utah Health Collaborative.

APPENDIX G: SUBMISSIONS FROM THE PUBLIC
This file represents information submitted by the public related—but not limited—to the following questions:

- **Healthcare Goals**: We want to make healthcare easier to pay for, be fairer, and have better results. What goals could we create to make that happen?
- **Pain Points / Challenges**: What are the biggest pain points or challenges patients experience when trying to get care?
- **Creative Ideas**: What are creative ideas for lowering costs and increasing health for all Utahns?
- **Barriers**: What stops Utah's healthcare system from trying new ideas?
- **Recommended Priority Areas**: What are areas that we should focus on for innovation and collaboration? (For example, mental health, preventing chronic disease, access to clinicians, access to personal health information.)

APPENDIX H: LARGE STAKEHOLDER FORUM SUMMARIES
This folder contains summaries with learnings from the six Large Stakeholder Forums held in March and April 2022. These invites were open to the public and registration was sent out via the Collaborative's newsletter and also targeted outreach to key stakeholders identified by the Executive Committee and forum leads. The general summaries were sent out to all registrants and the Executive Committee summaries were developed to highlight key takeaways for each of the committees.

- Patients & CBOs #1 (General Summary and Executive Committee Summary)
- Patients & CBOs #2 (Spanish-speaking) (General Summary and Executive Committee Summary)
- Patients & CBOs #3 (General Summary and Executive Committee Summary)
- Payers (General Summary and Executive Committee Summary)
- Care Delivery (General Summary and Executive Committee Summary)
- Employers (General Summary and Executive Committee Summary)

APPENDIX I: AD HOC FORUM SUMMARIES
This folder contains summaries with learnings from sessions held with smaller groups.

- Association for Utah Community Health
- Community, CBO, and Patient 1:1
- Disability Law Center 1:1
- Equitable Coverage Committee
- Fourth Street Clinic
- Intermountain Patient Advisory Council
- Local Health Departments

- Medicaid Agency and Managed Care Organizations
- Oral Health Coalition
- Patient Design Studio
- Physician Groups
- Utah Academy of Family Physicians
- Utah Department of Health and Human Services Executive Director's Office
- Utah Health and Human Services Interim Committee
- Utah Health Information Network Board
- Utah Health Policy Project
- Utah Medical Association
- Utah Hospitals

APPENDIX J: COMMUNICATIONS TOOLKIT

This folder contains information related to communications.

- Branding and Templates
  - Word Template
  - PowerPoint Template
  - Color Palette
  - Logo Full Size
  - Logo Bug
- Past newsletters
  - General Updates
  - Innovation Highlights
- Distribution lists
  - Newsletters
  - CEO forum

APPENDIX K: ANALYSIS OF PUBLIC INPUT FOR PRIORITY AREAS

This file illustrates the prominent categories discussed throughout the alignment strategy input process. The categories provided relevant context while the Executive Committee decided on Priority Areas for the Collaborative.

APPENDIX L: STAFFING RECOMMENDATIONS FROM THE ORGANIZING COMMITTEES

This file compiles recommendations from the four sub-committess of the Collaborative where they identified staff and resources required to fulfill the work of the Collaborative.

Adoption of Charter

The One Utah Health Collaborative Charter was adopted by Executive Committee members at a meeting on July 7, 2022. Members not present for the in-person vote voted to approve the charter electronically.

Members issuing approving votes are listed below:

Ryan Morley, SpringTide Ventures - Co-Chair
Rich Saunders, State of Utah - Co-Chair
Scott Barlow, Revere Health - Member
Greg Bell, Utah Hospital Association - Member
Marc Bennett, Comagine - Member
Bill Crim, United Way of Salt Lake - Member
RyLee Curtis, University of Utah Health - Member
Sebastian de Freitas, Select Health - Member
Natalie Gochnour, Kem C. Gardner Institute - Member
Michelle Hofmann, Utah Department of Health - Member
Chris Klomp, Collective Medical - Data Committee Chair
Chet Loftis, PEHP Health & Benefits - Member
Betty Sawyer, Project Success Coalition - Member
Oreta Tupola, Utah Public Health Association - Member
Rep. Ray Ward, Utah House of Representatives - Member
Sarah Woolsey, Association for Community Health - Member