OeHI Office of eHealth Innovation

Meeting Minutes

eHealth Commission

March 13, 2024| 12PM| Virtual Meeting Only

Type of Meeting	Monthly eHealth Commission Meeting
Facilitator	KP Yelpaala, *eHealth Commission Chair*
Note Taker	Amanda Malloy
Time Keeper	Amanda Malloy
Commission Attendees	KP Yelpaala, Sophia Gin, Michael Archuleta, Jackie Sievers, Kevin Stansbury, Micah Jones, Rachel Dixon, Misgana Tesfaye, Patrick Gordon, Krystal Moorwood, Joel Dalzell (sitting in for Parrish Steinbrecher), Cory Hussain, Michael Feldmiller Absent: Toni Baruti, Mona Baset, Amy Bhikha

Minutes

Call to Order

KP Yelpaala

- Roll call was taken. 9 voting members present. Quorum Met: Yes
- Voting of Meeting Minutes: YES
- Corrections for January and February eHealth Commission meeting minutes: None
- Add March Meeting Minutes to Next Meeting in April
- In favor of approving: Krystal Moorwood and Michael Archuleta
- Opposed: None

Announcements

KP Yelpaala

- Today on our agenda we have a couple presentations, one from Karen from the OeHI team who is a Senior Project Manager and Sophia, our fellow eHealth Commissioner, as well. So I am going to pass it over to Stephanie to continue on with our agenda

Stephanie Pugliese

- Good Afternoon - just a couple of announcements before we move into our content today. Firstly, you may have noticed that Jason Greer is not here and Michael Feldmiller is. He will be taking over the role of eHealth Commission Advisor from Jason and we are just waiting on his formal appointment, so welcome Michael. Hopefully we will officially welcome you next month as we are excited to have you. The other announcement is that the Behavioral Health Administration (BHA) is looking for members to join two of their advisory councils. They have the BHA Family Voice Council and the BHA Advisory Council. I will put a link to their applications into the chat for anyone who is interested or would like to help share this opportunity with the broader community. Those are all of the announcements I have today. Based on that, I will kick it over to Karen Haneke and Sophia Gin.

Karen Haneke, Sr. Project Manager - Information Governance Program Update

- I wanted to start with talking about what we will go through today. These are the topic area slides that we have and are asking for your feedback and input today. We need to kickstart our direction and so I will go into detail about why we are discussing this topic. We are going to level a little about what the State of Colorado does for information governance across the state and its agencies. We will define information governance in the context of this commission and OeHI in general. We will talk about the OeHI accomplishments as they relate to our Roadmap initiatives and then hopefully the bulk of this content will be regarding where

we should go next with feedback from all of you.

- In essence, information governance is one of the five pillars listed in our Health IT Roadmap which is something we have been committed to. Those folks who have been commissioners for a while will have seen all kinds of activities and work groups that have happened over the years. Governance should document essential policies, protocols on data ownership and data sharing and should focus on privacy, security, access consent and use in a general background definition. OeHI's role in all of that is to be a steward of information governance. We are generally not the creator or owner of any data, however, we all interact with data and we need to make sure that this data is managed appropriately for the healthcare of Coloradans and to improve our communications overall in interoperability. Ways that OeHI has done this in the past and can do in the future involve convening health information committees to meet state agency and community needs. We can participate and give feedback to state agencies and we can also provide materials, policies. So today as we go through these slides, we will discuss a little bit further how OeHI defines information governance, what state agencies are doing to ensure this governance, and we will walk through OeHI's history in this space. We have had some good wins along the way, but right now we would love to jump start that. We really want to hear from you - is OeHI doing enough as an information governance data steward? That is what we want to get to and to chart this in the format of next steps.
    - Stephanie: As Karen mentioned, OeHI is a part of the larger state information governance effort. Amy Bhikha runs the state side of information governance but because she is not here today, I will be running through this with everyone. OeHI's goal is to tie into information governance as much as possible and to support the framework that Amy is building with partnerships with other agencies. This isn't something that OeHI feels they need to run in and fix it all, but we are supportive in the efforts that Amy and her team are doing. As this slide shows, and as Karen mentioned, the state has its hierarchy of data governance starting with the Data Governance Advisory Board (GDAB). I serve as a member of that as well as a number of eHealth Commissioners. This is in partnership with the Chief Data Office and at a strategic level, those universal data policies and rules and identifying opportunities for us to work together. It cascades down to agency level governance. Each agency has its own specific framework and practices of data governance. It cascades down even more to specific missions. I sit on the data governance advisory board and we have a number of OeHI project managers that sit in on those associated work groups. There are three GDAB work groups focused on governance, data sharing, and one other. I also participate in the joint agency interoperability leadership council. That is a group of cross agency folks focused on governance for the JAI project. Misgana and his team presented it late last year. We really try to fill the role of a bridge for governance and work across agencies and with agencies but we are not leading the entire state. And with that, I will pass it back to Karen.
- Karen: With all of that context in the back of our mind, framing the information governance for OeHI and the eHealth Commission is to figure out how we can support those activities related to the data governance that happens across the state and also across healthcare providers in the social health perspective. We want to find a way that we can be stewards of this work where we can support without overstepping their people's activities.
    - Where can we dig in? Where can we be a partner? Are there policies and procedures that we can put in place? Is there legislation that should be proposed? What should be done to ensure the State of Colorado has good governance and how do we ensure that state partners can tap into that information and understand what is required of them? What materials could we provide to help the greater community at large? OeHI is not responsible for fixing the state's data governance. We know that institutions have their own governance policies. We really want to focus on those information items that we can help with to support those ongoing activities. What has OeHI done in its stewardship role?
    - The three bullets you see were taken right out of the roadmap and are what we said we would do. One of those is to provide shared governance models for the community. Back in September of 2021, we developed the Colorado Health Information (CHI)

Governance Guidebook. It is useful for providers to know when and how they can share data. Secondly, there has been robust participation in state agency and local governance efforts. We serve with GDAB, interact with the Chief Information Office, we collaborate with the Joint Agency Interoperability (JAI) project, and we work very collaboratively with HCPF on agency governance policies. As we are aware, the Social Health Information Exchange (SHIE) is kicking off and we are in the process of assisting with the governance activities that will be required to ensure that that project is a success. As far as assisting community partners to understand governance policy.

- For years, in the past, OeHI has convened the Information Governance Workgroup under the eHealth Commission which drove the effort for developing the CHI Guidebook and to provide a forum to discuss the issues that surround governance policies, federal regulations, and how various groups were responding to those. We aren't doing that right now and it is something that we would love to hear from you all should we continue to do that.
- Where should we go next? Is there new guidance we should develop? Are there new policies we should recommend? Is our participation in the groups we listed enough? Do you have ideas of other groups we should engage in that we haven't in the past? And as far as assisting community partners in understanding governance, we do have an internal SHIE information governance committee but we don't have a workgroup that serves the social health community so do we need that? Do we need to reinstate the eHealth Commission workgroup? And if so, what would be its mission?
  - KP: I appreciate this Karen. Governance itself is a very broad construct so I think, how might we think about sub-prioritization within the theme or where a group on this topic might prioritize. AI is definitely a thematic area around data governance. How might we prioritize helping folks wrap their head around it since it is such a broad scope? Do you have any guidance or ways we might think about that?
    - Karen: I realize that and we have a lot of new folks here who might not have been engaged in workgroups in the past. When we had health information workgroups and governance workgroups in the past some of that was an effort on what could we do to improve data sharing, for example, between behavioral health data and primary healthcare providers - how could we improve that kind of coordination? As we all know, we have a new rule that has been put in place that will start to reframe the way some of this data can be shared. That would be one topic area that we could become involved in.
  - Cory: I am a physician who does a lot of data and data analytics. In terms of the data that you're talking about, has anyone done data validation to see the quality of the data and how useful it is to the stakeholders that will be using or receiving or sharing this data?
    - Karen: When you are talking about the quality of the data are you talking about healthcare HIE related information? I actually don't know that but it is a question we should ask our HIEs about data quality but that could be a greater topic area for future discussions.
    - Jackie: Hi Cory, I am Jackie with QHN. We have a team that works on that looks at that quality and what data can be used for analytics and it is certainly something we can talk about more. It's an important point - we do not just want data to sit there in a database but to actually have some value.
    - Cory: Especially to our stakeholders who will be procuring and using this data. As you have mentioned, behavioral health, social determinants of health, health related social needs data and knowing what is being exchanged and how useful it is to our stakeholders downstream. It is going to be really useful and very successful.
    - Karen: I don't know from a HIE perspective if there is a way to query how often data is accessed in general by what groups and what types of

information. I think that would help us understand the impact and where folks are interested in receiving this HIE data and perhaps any gaps.

- Jackie: There are ways that we can query that. I would just want to be clear about the distinction between HIE data and SHIE data as those are different things. I think there are a couple of things we can do. If there are particular areas of interest in the commission, I can take those back to our teams and ask them to delve into it and provide some information back. We could bring those experts here if the commission would like to hear from them. I think that it could be a really interesting conversation.
- Cory: We could probably start with SHIE data because that is really what we have been concentrating on. HIE data is Contexture - I see their CDA formats all the time. But the SHIE data because it's newer there's not a lot of workflow processes within our healthcare environment that requires collecting this data on their radar. Social Determinants of Health (SDOH) data is at the bottom of people's priorities in terms of housing insecurity, transportation, or food insecurity. I am just worried that we will build a pipeline but there won't be much that is fed to it.
- Karen: Thank you and that seems like a theme that we need to revisit to get an understanding for data equality regarding whether it's HIE or SHIE just to get an overview understanding of that information and to understand where that data is being used in its current state.
- Rachel: Your bullet around community partners understanding the policies and their roles in enforcing them. It seems like the point that Cory is raising about the usability of this data for community partners, could that be something a work group could form? That seems to me like a really good use of a work group.
- Karen: We have been having these conversations and there was a lot of initial effort into understanding the need for SHIE data. As we start the build out we are going to have some areas where we need more community input on what we are doing, where to go, and what our products look like to ensure what we are doing is complementary to the information that is already available.
- Patrick: In terms of the data, what is interesting to me, is that the highest volume data opportunity is screening data. That screening data collection, at least in the partnership we have with QHN, has been robust and sustained. I know that many providers are engaged. It seems like this could be a starting point. Where the limitation runs in from my perspective is not so much data, but the community piece. Again, my strongest point of reference is CRN where there is very good community awareness, very good community engagement but the volume of Community Based Organizations (CBOs) participating in the network needs to grow. We need to create a value proposition for them and we need to not only grow the network but begin developing processes to develop accurate information about them and to make sure the organizations that we are working with are good partners who can live up to their mission statements. When making referrals we need to be careful with the quality of the referrals that we are facilitating. The bottom line is the easiest place to start in policy opportunities and information governance would be the statewide screening data. That might be the fastest path forward.
- Gabby: Thank you for the conversation, commissioners. I have a couple of things to weigh in on. What I would love to do is just open the door for commissioner input and come up with the best way to approach this because this isn't something we can develop or do alone. One component that I really want to highlight is the upcoming SHIE RFA

(Request for Applications) that will be coming out in the next couple of months. We really have a heavy community engagement focus and of course it won't solve all of the challenges we have here, but will provide a direct path to fund community partners. The second thing I want to highlight is that we have been working with Resultant for four months. We have done a ton of work in four months to start the process of doing discovery for this huge initiative. I'm really proud of what we have accomplished so far, but there is still a very long on ramp to go. We have really been trying to prioritize talking with providers who work with folks day in and day out and really trying to incorporate community voice in ways that I think we haven't done to the extent that we are doing now. I would really love to know anywhere you feel we should be plugging in or any groups that we should be talking to. Just as a call to action for all of the commissioners is that if you have areas that you would like us to partner and have these discussions and conversations, please send them my way. Last but not least, I would love to hear from folks that OeHI has engaged with and funded in the past to start doing SHIE work. We really need to be building off of the successes and also the lessons learned from those initiatives. We want to hear from you all and to understand how those projects have gone and how the current HIE work is going because it is the foundation that we are building from.

- Karen: Thank you Gabby. There seems to be a lot of interest in forming a new information governance workgroup focused around SHIE, perhaps around the larger community as well. We can take that as an action.
- Sophia: If you remember, in the beginning of Karen's presentation, it would be a much broader question. There is a work group called Data Governance and I worked with Karen through the process to be really specific of a scope and what is the problem we are trying to solve? I'm really encouraged by conversations and the questions that many of you have spoken today. It sounds to me that the broader governance is held by different agencies within the state. You have different state agencies that have to comply with the data governance standards. That, to me, shouldn't be the priority of the OeHI group. I'm so glad that this is where the conversation has gone because it gives us a more concrete context and target so that we aren't trying to address everything that's out there. We are really encouraged to see all of this participation.
- Jackie: Just to expand on Sophia and Gabby's thoughts we are working with OeHI and Resultant to start really looking at workflow and some opportunities to dig in. I think that might give us some of those narrower perspectives where we see opportunity and where they might be missing and what might be stopping or slowing our community partners down. I'm really excited about that and it might help us know where this effort can be focused next. There is so much potential there that we can go in a lot of directions so maybe we will get some opportunity from it.
- Karen: We need to rely on our eHealth commission expertise for some sort of work group to guide us and give us input as we go and this can help us get some of those ideas going. It appears that we need an information governance work group focused on SHIE. My question for you now is should we do that by spinning off a subcommittee of this group or is there enough general eHealth commission interest that we try to work this into the entire eHealth commission space somehow for the larger committee? Any thoughts on that?
- Michael Feldmiller: I am a proponent of looking at the larger scope in addition to the SHIE. For instance, Colorado Community Managed Care Network (CCMCN) is working closely with OeHI on rural analytics so we are probably starting to get into those types of conversations of what

social data we could integrate for rural areas. I definitely see a use case for a broader scope of the information governance
- KP: Thank you Karen, this has been great. I am just tracking time and I know we have a couple more presentations. This has been a really great discussion and I think, as I've been listening, there has been a lot of substantive feedback. At the end of the day, the heart of data governance are rules and there are basically three rules that need to be managed: Federal government rules, state government rules, and agency rules. Those three layers need a clear objective for share permissions. If certain federal rules are what they are and govern certain people's data we aren't changing those. I think that to get this moving, that it needs its own kind of working group. I think the first question for that group is where are the shared objectives building on prior work? There have already been discussions about governance so can a group come to two or three tactical areas where they would say that there are two or three areas with shared objectives as a group. So I think that instead of bringing it to a broader group, we need a subcommittee to form and bring more specific things back to the commission for not only discussion but with objectives to work on. If there is some legislation on a state level - something policy wise - that we feel like OeHI can advocate for. I think right now there are a few unknowns but I'll leave it to Stephanie and team to get input from the commission. It sounds like it needs its own group to move the topic along and then we can bring it into broader commission agendas.
- Karen: Thank you KP and that is very well framed. I think at this point we welcome any further comments but as you mentioned, we have gotten a lot of great feedback. Thank you so much we appreciate all your comments and feedback.

Ashley Heathfield, Sr. Project Manager - Telehealth Project Updates
- I just wanted to provide some updates on the overall updates on the projects for telehealth. These are not all of the projects we have, but I just wanted to give updates as some of them have wrapped up or are wrapping up soon. The objective for these projects is improving equity in telehealth access for Coloradans and support to community providers. I wanted to provide some guiding questions so as you hear about the projects, we'd love your reactions, ideas, and feedback, as well as needs or opportunities these projects don't address, and any additional telehealth related projects you've got percolating.
- Here are the projects that I will provide high level updates on:
  - CHIRP (Colorado Health Innovation Resource Platform): A few months ago, I gave a presentation on CHIRP which included the recommendations and projections for cost, building the platform and maintaining it. As a team we have decided to pursue working with the Southwest Telehealth Resource Center (SWTRC) to enhance support to Colorado providers through their role as the regional telehealth resource center. They have an application coming up in August.
  - Telehealth Payment Parity Project: As many of you already know, OeHI partnered with Prime Health in 2021 to establish the Regional Telehealth Learning Collaboratives (RTLCs). The goal of the RTLCs was to advance the statewide adoption and coordination of telehealth technologies. Through this initial effort that included three geographic regions spanning urban, rural, and frontier areas, we heard from voices across the state to gather barriers and input, which resulted in recommendations for an equitable, impactful, and inclusive statewide telehealth infrastructure. We also worked with Prime Health on a survey to providers and healthcare staff that included insights and questions from more than 25 state departments and agencies, research organizations, provider organizations, and community partners. An initial survey was disseminated in 2021, and that was followed up by another one in summer 2022. Through these efforts, we learned of several barriers that make telehealth adoption

and implementation difficult for providers. Among those barriers was reimbursement - we found that many providers reported complexities, challenges, and claims denials for unclear reasons when attempting to bill for telehealth, and particularly confusion when it came to contracts with commercial payers. Safety net providers often rely on reimbursement from commercial payers to sustain their practices, so complex billing that is costly and time consuming can lead to adoption and sustainability barriers for these practices particularly. We asked CIVHC how we could leverage the CO All Payers Claims Database to explore payment and denials parity to confirm or rule out wide-scale issues with telehealth reimbursement, which led to the Telehealth Payment Parity Project. We also wanted to understand telehealth utilization disparities at a more granular level, and explore what social factors have the highest impact on telehealth utilization, leading to the Telehealth Equity Dashboard.

- For the telehealth payment parity project, CIVHC pulled in 70 CPT codes (which mostly mirror the codes they analyze for their Telehealth Services Analysis), representing 9 different service areas. This represents 8.6 million total claims across 27 commercial payers from 2020 and 2021. Through a partnership with the Division of Insurance, we also received data pulls from 4 major commercial payers in Colorado for individual claim lines for services delivered in 2020 and 2021, including an explanation for any reduction or denial of the claim. The final dataset included over 540,000 claims. Non-adjudicated claims. For this project, all of the payers were masked or had aliases created, so OeHI cannot identify any payers in this project. This initial analysis showed that reimbursement for telehealth is lower than in-person services, although the gap in reimbursement is closing between 2020 and 2021. The reimbursement disparity varied by commercial payer, with only 3 payers reimbursing telehealth at equal or higher payments than in-person. It also varied by service area. For example, the biggest gaps in reimbursement between in-person and telehealth in 2021 were for preventative medicine services which were $37 lower, and for consultation services $42 lower. The analysis also found that the gap between in-person and telehealth reimbursement was higher for rural areas at $27 vs $22 in urban areas. The denials side of the analysis also found that telehealth claims were more likely to be denied than in-person claims, which varied by service category and payer, but not by geography. The chart on the right shows the most common reasons for denial among telehealth claims compared to in-person claims. While we don’t know from this analysis if these claims were eventually reimbursed, I think this speaks to the additional administrative burden that organizations are facing when attempting to bill for telehealth, even with this small data set. Before going into the next project, I just want to invite folks to ask questions or provide feedback throughout the presentation, don’t feel like you need to wait until the end.

- Telehealth Equity Access
  - Goal was to better understand how social factors impact telehealth utilization, and an attempt at better understanding disparities in telehealth utilization in the state. This analysis married American Community Survey variables with claims data in the APCD, and CIVHC performed statistical analysis to measure the relationship these factors have on utilization at a state and county level. This dashboard also provides a more granular view of telehealth utilization at the census tract level vs only at the county level. I don’t know that I have time to demo the dashboard, but it's linked on this slide and I'm happy to come back to it at the end if there’s additional time and interest to do so. And I will put a link in the chat now in case anyone would like to take a look at it. Not surprisingly, the counties with the highest telehealth utilization is in urban

areas of the state, which is in line with other analysis. However, when you drill into those counties, you can see disparities exist within those counties.

- Cory: Is there a language filter especially for English, Spanish, and non-English/non-Spanish
- Ashley: There is a variable from ACS and it is around language and people not speaking English at home. Language is a component there. I think there is a lot more refinement we can do with the dashboard. Looking at the state level, the only one that had a variable was Veteran status but then when you get into the county level that completely changes. So I think we are still fine-tuning this but yes language was one of the variables.
- Sophia: I was actually really surprised by the cost difference and the reimbursement difference between urban and rural. Did you say that these are commercial payers?
- Ashley: It is only commercial payers in this analysis, yes.
- Sophia: Wearing my commercial payer hat, I wonder if this has to do with a negotiation power. It's as if these are old contracts that never got looked at again.

■ Not surprisingly, the counties with the highest telehealth utilization is in urban areas of the state, which is in line with other analysis. However, when you drill into those counties, you can see disparities exist within those counties. On the flip side, the counties with the lowest utilization were rural counties. You can see the ACS factors associated with these counties, and I've also marked the counties that have the least amount - less than 20% of locations served according to the Colorado Broadband's map. In addition, I've marked the counties that are participating in the telehealth library pilot, which I'll describe more in a few slides. Based on the findings from these projects, OeHI is partnering with CIVHC again to refresh the payment parity analysis to see if the trends in telehealth reimbursement disparities are continuing, and what the financial impact of these disparities are on providers. We want to ensure safety net providers are supported in offering and sustaining telehealth services to their patients, and making sure reimbursement legislation is happening is maybe the biggest way for us to do this. We are also working to better our understanding of how OeHI can support the communities in Colorado with the lowest telehealth utilization to make sure That work has just started and is expected to wrap up by the end of this fiscal year.

- Kevin: Part of what we've been reasonably successful with in rural areas is to convince payers that we don't have a separate bank of providers that are just providing telemedicine services. My primary care physicians are seeing patients in person and they are also doing some telemedicine calls so there is greater parity between in-person and telemedicine visitation. For the urban, I wonder if part of that is that we know there are providers that specialize just in telemedicine so they are all about volume. I also wonder if it is part of their negotiation with the payers.

○ Sexual and Reproductive Chatbot:

■ Another project expected to wrap up this fiscal year is the sexual and reproductive chatbot project with Clinic Chat. This project actually launched

in late 2022, and Clinic Chat worked with Boulder Valley Health Center and Colorado Black Health Collaborative on two instances of the chatbot, which launched on their websites in June 2023. The chatbot can provide vetted and accurate information on the topics on the left, and as of March there have been 409 unique users, and overall the chatbots are seeing roughly 35-45 users weekly. The average number of messages a user asks of the chatbot is 4.3. There have been 34 appointment clicks for BVHC (Boulder Valley Health Center), and the donut chart shows the combined top themes of the questions or inquiries to the chatbot. We could have sliced and diced this several ways, as some of the legal questions had to do with abortion and within abortion there were themes around cost. Clinic Chat is planning to launch a chatbot with the Colorado Organization for Latina Opportunity and Reproductive Rights soon, currently COLOR (Colorado Organization for Latina Opportunity and Reproductive Rights) is reviewing the additional prenatal information they requested to be available in the chatbot. Clinic Chat is also having conversations with other health care organizations, and we'll have an update on the outcome of those conversations in May.

- Library Telehealth Project
  - The last project I'll talk to you about today is the Library Telehealth Pilot. This project is really about leveraging existing infrastructure to enable people in rural areas to benefit from telehealth while the Broadband Office works on getting households connected. These awards have ranged from $500 - $21,000, and libraries are using the funds to implement telehealth hubs within their buildings - private, equipped, accessible spaces that someone can have a telehealth appointment with a provider of their choosing. For libraries who don't have the space within their building, they are using funds to purchase "check-out" kits that patrons can take home given they have the connectivity to have an appointment at home, but maybe need a little boost from a mifi or need a how-to on the equipment. There is actually one library in Colorado that does not have publicly available Wi-Fi for patrons outside of workforce needs, and this grant is enabling them to pay the cost so that next year it can be absorbed by the town. This project is really going to have an impact for folks and it has been really great to work on.
- KP: That was a great presentation and great job to you and the team on a lot of really important insights. There is a lot of good stuff to build on there. Are there any other questions or comments for Ashley?
  - Rachel: I will echo KP in that this was a great presentation. Kudos to you and the whole team, these are really innovative and impactful projects. People have been trying to make library telehealth in Colorado happen for years. So to see what you've done in partnership with the Colorado Libraries is so great and I can't wait to see what else you do. Congratulations, all of this is really exciting.
  - Ashley: Thank you Rachel. I also wanted to say that Pueblo Library which is one of the most rural libraries just did a launch event to let the community know about the services. We are hoping to get more dates scheduled for those and find out when they are.
  - KP: Thanks so much everyone. I really appreciate the presentations today and

the engagement as well.

Public Comment Period

- We do not have any public comments that were submitted, but we do have a question:
  - Alan: I am from Alamosa, CO and this might be more of a comment than a question. I am wondering about OeHI's role in enabling standardized data through the HIEs. We were recently involved in a project to standardize some of our demographics including race, ethnicity, and language. We were asked to map a hybrid language specification. We have run into this before with SDOH and thinking about how/where the standardization happens and from a technical standpoint. If we are always asking the data supplier to standardize information, I think we alienate a lot of smaller data providers because then they have to go back to technology vendors and ask them to make changes which is sometimes an expense and other times it is not an expense. I wondered if there is any governance around where that standardization happens. It might be an area that a subcommittee can make recommendations for.
    - Stephanie: Thank you so much Alan, we appreciate that comment. We completely agree as this is something that we are focused on and the HIEs as well. We want to make sure that we are aware at the provider level and how we can support that. We would love to talk more and will follow up with you and potentially work with you on the governance piece.
    - Micah: HIEs do standardize and normalize data that comes into our system but I think part of the question that Alan was bringing up is that standardization on the provider end is a burden that weeds out smaller health care providers. Standardization is a very important item that we have to figure out. During the conversation that we had about information governance, I kept thinking that the issue that keeps coming back to me is that there is no standard data set. In addition to the HIEs normalizing data, the data still has to be pushed out back to the data recipients but also in a manner that can also meet their systems as well. That actually adds another level of complexity especially when you're factoring in that there are all kinds of different standards that are in play. It gets really complicated when you think about all of the data standards that you may have to apply to different data in order for it to meet the needs of each individual system. One of the things that could be pushed is a single standard that everyone can agree to so that way data can upload more easily.
    - Cory: I do have a question for Alan because I found that comment interesting. You mentioned something about a hybrid language field. Can you just elaborate a little bit?
      - Alan: There is the SAP 1, 2, and 3 language. When I was trying to find the key to map, there seems to be a hybrid of the three but I'm not sure where that came from. It did mean extra work in trying to figure out what the hybrid mapping was but also required us to go back to our vendor to request changes to the standard that we already had mapped. Again, we are a pretty motivated organization.
      - Cory: I just want to highlight that. Vendors are the ones who determine the data collection and standardization in their electronic systems and that is one of the places, that I think, we are the people who get to say that these z codes are going to mean "this". You need to make sure your vendor is in compliance because this can be a national standard of how to define SDOH in each of those areas. This is a great example of someone telling us how this actually happens.
      - Alan: Sometimes the vendors are small and sometimes they are large - when small they don't have the capabilities or they are large and sometimes, if you're a smaller organization, you try and change that larger vendor, you can imagine the challenges that come with that.
    - KP: Thank you, Alan for sharing. We got some really good insights from Micah and Cory and I'm sure the rest of the group is thinking about this

standardization issue as well. We appreciate you sharing your experience with us today. Do we have any other public comments or folks wanting to jump in? Next we will hear from LG for closing remarks.

- LG: Thanks KP. Good afternoon everybody. I always enjoy hearing the latest from the OeHI team, and am impressed by the amount and quality of work accomplished by the team and this Commission. Karen and Ashley are amazing examples of thoughtful and enthusiastic partners who lead collaborative work across many organizations. OeHI serves an important role in this capacity, working within and across our state agencies and throughout our entire state to form partnerships and connect the dots for our health IT ecosystem. In the spirit of partnerships, last month, Stephanie and I attended the White House Youth Policy Summit. This opportunity gathered youth organizations, federal agencies, nonprofit partners, and others to talk about what we can do to better support our youth, at all levels of policy and across a variety of programs. It was encouraging to be amongst so many solution-oriented individuals and groups, and hear directly from youth about what they want to see in their spaces and lives. As we continue working on the strategy refresh for the health IT Roadmap, I want you to please consider audiences and partners we haven't worked with before, or whose voices are not frequently represented. I am excited that the OeHI team has decided to include a more patient-centered perspective in this upcoming Roadmap, behind every piece of data, there is a patient centered story.

Action Items

KP Yelpaala

- *Next meeting April 10, 2024*

Motion to Adjourn

KP Yelpaala

- KP Yelpaala requests motion to adjourn
- Misgana Tesfaye motions to adjourn
- Patrick Gordon seconds the motion
- Meeting adjourned at 1:25 PM MST