OeHI
Office of eHealth Innovation

Meeting Minutes

eHealth Commission

November 8, 2023 | 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, Jackie Sievers, Art Davidson, Kevin Stansbury, Krystal Morwood, Misgana Tesfaye, Rachel Dixon, Sophia Gin, Patrick Gordon, Jason Greer, Micah Jones, Parrish Steinbrecher, Wes Williams Absent: Michael Archuleta, Toni Baruti, Mona Baset, Amy Bhikha

Minutes

Call to Order

KP Yelpaala

- Roll call was taken. 13 voting members present. Quorum Met: YES
- Voting of Meeting Minutes: YES
- Corrections for October 2023 eHealth Commission meeting minutes?
- Corrections: None
- In favor of approving: Krystal Morwood & Art Davidson
- Opposed: None

Announcements

Lieutenant Governor Dianne Primavera

- I'm really proud of the progress we have made in just a few years. Saving people money on health care has been a priority of the Polis/Primavera administration since the beginning as a part of our quest to build a Colorado For All. First, I am excited to share a preview of some of the key priorities in our budget.
    - Over the past 5 years, Governor Polis, myself, and a partnership with the General Assembly have made saving people money and increasing access to healthcare a top priority. To do that, we passed three insurance programs and that saves people between $2800 to $7500 on health insurance premiums for a family of four on the individual exchange. We have estimated a total savings for Colorado exceeding $1 billion since 2019. And nearly $300 million in the last year alone.
    - We also created the landmark Colorado Option to drive competition and lower costs in the individual and small group markets.
    - We have also tackled high prescription drug costs by becoming the first state to cap monthly insulin costs at $100 per month. Also establishing the prescription drug affordability board and have worked to increase hospital transparency so the state can take action. We believe that all Coloradans deserve to have access to the care they need and we will keep working to lower costs, remove barriers to care, and put people first.
    - This budget adds services for people of all ages such as urgently needed Behavioral Healthcare for children and adolescents. As well as expanded home care visits for new parents, coverage for DACA enrolled children and pregnant adults, and autism services for children enrolled in CHIP Plus.
    - In this budget we will double down on saving Coloradans money on healthcare with investments totalling $138.3 million dollars.
- Overall, this budget builds on what we have accomplished by continuing to make investments that will increase access to care such as Social Health Information Exchange (SHIE), expand

services for children, support our direct care workforce, strengthen public health response, and support behavioral health. We look forward to another fantastic year of important work,

Stephanie Pugliese

- No new updates

Rural Connectivity Program - Stephanie Pugliese and John Kennedy

- Stephanie Pugliese
  - Overview of where we started
    - In 2019, we started with a baseline assessment of 49 of the 84 Critical Access Hospitals (CAHs) and Rural Health Centers (RHCs) who were not connected to the Health Information Exchanges (HIEs). We also identified that non-federally certified hospitals and clinics were not connected to the HIEs. We heard the request for shared analytics as well as technical support.
    - In 2021, we submitted our first connectivity request to focus on connecting those CAHs and RHCs to build a shared analytics platform, to begin the shared technical assistance program. That was passed with the support of our Lieutenant Governor, our Medicaid colleagues, and the Joint Technology and Joint Budget Committee. With that, we received nearly 6.5 million dollars with a state and federal match. As soon as we got that money we started working with a number of our partners to start this work.
    - In 2022, we submitted the second connectivity request. This was focused on what we call the independent providers - these are the non-federally funded hospitals and clinics. This was less of a focus on that higher federal match, with the recognition that we really needed to invest in the technology and infrastructure of these clinics. With the support of our Lieutenant Governor, our Medicaid colleagues, and the Joint Technology and Joint Budget Committees, we received nearly $12 million in July 2022.
    - In 2023, we submitted the first Sustainability Request and this focused more on funding to maintain connectivity to the HIEs and to continue to support rural providers to invest in their own infrastructure and technology. We received approval at the end of this legislative session to award $100,000 per CAH and $20,000 per RHC on an annual basis.
  - Where we are now
    - In the first connectivity request, we have connected all 84 CAHs and RACs to the HIE. The Community Analytics Platform has been developed and is in use; also known as the Shared Analytics Platform. And we have technical assistance underway.
    - In the second connectivity request, we have connected 19 of the 67 independent providers to the HIE network. We are in discussions with 4 additional providers to connect. And again, technical assistance is underway.
    - Regarding the sustainability request, this was just passed about half way through this year, the rule is with the Medicaid Services Board pending approval. The first payment will be issued in March 2024 and each subsequent payment will be issued annually each State Fiscal Year (SFY) on August 1st.

- John Kennedy
  - In the calendar year of 2024, OeHI will release payment on March 1st and August 1st. Our partners in the space have been absolutely amazing: CCMCN, Contexture, Kevin Stansbury, Michael Archuleta, as well as Stephanie Pugliese. I'd also like to thank Gabby Burke for starting this 4 years ago.
  - Program Goals
    - To connect providers to Colorado's Health Information Exchanges.
    - Support rural providers to adopt health information, data sharing, and analytics through information support.
    - Providing analytics and tools to support emergency response, care coordination, and quality measurement.
  - Why this program? Why now?
    - Equity, Access, and Affordability are all in alignment with the OeHI roadmap and addresses interoperability
  - Benefits to the providers
    - With our outreach efforts, there is a synergy of data and information that helps providers. Benefits include unnecessary Emergency Department (ED) admissions, analyze trends and healthcare costs, review their patient population health information, and review trends for quality improvement
    - There is also free access to claims analytics reports that can be utilized to look at aggregate-level data for their organization
    - Providers can view their attributed patients and review ED and inpatient visits, pharmacy claims, utilization, costs, and more.
  - Data Vault
    - This graph shows the moving parts of all that goes into the data vault ecosystem, including CIVHC, HCPF, CDPHE, HIEs, Labs, provider data. It is pretty robust and is crucial information that has taken a lot of working together and many user agreements
  - Where we are now - Community Analytics Platform Reports - this shows how we have evolved as we have moved through the process.
    - Standard Reports: This is what we have built everything off of. Admission, discharge transfer summary, current and historical attribution, and Covid 19 reports are all the things we started with.
    - As we started listening to our providers and had our user group meetings, we really started to listen to what they wanted. Phase 1 reports show you where we went from there. There is a various list of reports which is pretty robust including detailed finance utilization, financial summary, patient episodes, and many more.
    - Then as we continued, we received more requests such as cancer, diabetes, Covid 19 vaccination tracker, etc. Outmigration and overlap is something new and I will discuss more about these later. This is something we have done to help in the space with the fear of our rural providers losing the patient. These reports help to show them who is leaving their system and where they are going so they can change their business model if they need to.
    - The next two slides show you what we have done in this space.
      - There is a statewide initiative in Colorado called the Colorado Cancer Screening Program. It is a national clinic and community organization whose goal is to provide evidence-based

interventions, patient navigation, and population-based research for cancer prevention and control. The Colorado Cancer Screening Program provides screening and technical support for healthcare teams to implement initiatives, to reduce barriers, and to improve access to care. The program is administered through the University of Colorado Cancer Center and is funded by the Cancer Cardiovascular and Pulmonary Disease grants program. CRHC has been offering technical assistance aligned with a report developed from program data. CRHC, include the colorectal screening as part of this report. This advancement is significant as it benefits not only rural facilities but also acknowledges the effort and readily offering these dashboards to inform their work.

- This slide shows the winding down of the public health emergency and Medicaid members who no longer have Medicaid coverage. The current and historical attribution report allows end users to view their Medicaid attribution population as designated by HCPF. This includes those who are newly attributed and those who have recently dropped off. End users also get insight into demographic distributions and how Medicaid members contribute to their organization. End users can identify with the cause that they share a patient population which can help increase coordination and collaboration efforts.

- User Group Meetings
  - One way that we communicate and work with our users is through our quarterly user group meetings. At the meetings we have: demos of dashboards in the data vault, increase awareness of the Community Analytics Platform (CAP) and available reports, collaborate on new reporting ideas, increase utilization and comprehension of CAP, gather information from users regarding enhancements to the platform, and better understand how users are using the CAP.
- Questions/Comments:
  - Kevin: I want to start by recognizing both Stephanie and John for their work on this and want to also mention Contexture and QHN. It may seem like we are dealing with data abstract issues but I have a number of stories that I'd like to share with the group at the appropriate time. This literally changes people's lives and improves their healthcare. One of my physicians is convinced that access to the HIE helps patient's lives so that we have better communication between the rural and the urban areas. As my friends also know, I have a number of concerns about this program. Unfortunately, it misses a couple of key providers in the rural areas. It targets CAHs with focus on the frontier and rural areas. There are a number of general hospitals, in rural areas, that serve high percentages of Medicaid populations and at risk patients. The most glaring example is San Luis Valley Health down in Alamosa. They are not a CAH but I think they can definitely be categorized as a safety net hospital. So my plea would be to look at those kinds of hospitals that serve rural areas even though they are a little bigger than the CAHs. The second plea is more personal. As part of my hospital system, I serve four primary care clinics and they are all referred to as provider based clinics. They are not certified rural health clinics so my clinics are not eligible for the additional grant money because of the way the rules are

written. I think you are leaving some key providers out of the equation. A lot of times those hospitals are not certified rural hospitals, and they are not independent, they are all certified by CMS and provide good care to patients, but I would urge the Commission to broaden those definitions because I think those definitions were made at a time when definitions were made too narrowly.

- John: I appreciate you bringing this up. We do recognize and understand that and thanks to Kevin for being able to articulate some of these things. Also for meeting with specific people like San Luis Valley Health and other hospital systems. There are outliers. There is a group of providers that are not considered a part of this program based on definitions. An example of this is a rural health center or a rural health clinic that is on the border of a metropolitan county, but strictly serves a rural county next to them, but because of their zip code, they are considered metropolitan. They don't qualify for the program. There are other examples of hospital systems that have had to work together on paper to make it and by doing so they have more than 35 beds on paper and that disqualifies them from our program. We are able to see that and recognize that so there will be another phase of this. And with the new phase, there are more who will be included since this first phase has left people out based on our parameters to the program. That is coming - I have already spoken to Stephanie and Chris Underwood (HCPF) about that and we are in agreement that this needs to happen. Currently, those that we just mentioned - the outliers - are excluded from the sustainability payment that Stephanie mentioned early on because they are not a part of the program. We want to be able to include them in the program and have them eligible for those sustainability payments. I think it will be a much shorter process because we have already completed this process twice.

- Kevin: One last point that I would make is that a number of these clinics that are provider based clinics already have connectivity; they are just not getting the sustainability grant to help with the ongoing expense. The second thing, I have had several conversations recently with Donna Lynn at Denver Health about the comparable missions that many of the rural hospitals have that Denver Health also has. We are all, essentially, safety net hospitals. I wonder if there is a way to try to capture all of these providers with a similar definition and to come up with some way to identify who truly are the safety net providers in the state. It's not just Denver Health and it's not always just CAHs or rural health clinics; there are a number of others. I think that there are a lot of providers who are out there who don't fit that definition that we often think of as hospitals and have a lot of resources. There are a lot of us out there that are struggling to make it and we do it because of our mission and need to serve our community and I wonder if there is a way that we can define those.
    - KP: I really appreciate this sentiment of Kevin and I think it is really important because these types of issues we want to create some sort of structure and definitions that create fairness and clarity. But naturally, there are always groups that find themselves

on the edge. So my question to you is - you spoke about the facilities that don't meet one definition but their patient mix is representing the rural populations. What are we talking about magnitude wise in the number of facilities, but also the number of patients they serve. Part of framing this is really looking at that because it is about the people. One way that we might think about definitions is not only geography based but patient mixed base.

- John: We need to take the focus away from the zip code and focus on, like you said, KP, the other items. In my mind this is a good thing. We identified what we set out to identify and now we see a better picture of where we are at.
- KP: I am putting a pin in this because I think we need an action item that defines this and gets the numbers. Let's put that down as an action item so that we don't lose it and can begin to map this out.
- Kevin: There are other providers who are serving the rural areas. I have great concern for what is happening with our nursing homes in rural areas. They are closing down at a rapid rate and if there are ways that we can provide them with data support or with some kind of additional funding to help them survive that would be very helpful. I do know that that is a little bit different of a connectivity issue but sometimes the nursing home is the only healthcare provider in a community and maybe they are served by a medical practice that's in the community. We have to figure out a way to consider including them as well.

- Art: The inclusion into the program - is that based on, I think something like 84 institutions, are we counting just the ones who are in this sustainability effort or just those who are in specific zip codes? How do the HIEs decide who to share information with you about?
  - John: The first group of 84 were federally recognized. The next group of 67 were independent providers also federally recognized - Rural Health Clinics. That was how we identified those two groups. Those two groups are eligible to be a part of the CAP (Community Analytics Platform). Part of that is being connected to the HIEs but it's really about being connected to the CAP for the rural program.
  - Art: Is there a vault or is it that there is a way to query the data in the HIE?
  - John: Both. It is an actual data vault that has additional information that helps drive these reports and that also feeds into and interacts with the HIE infrastructure.
  - Art: And the people included there are ones that were from certain practices or was it based more on geography?
  - John: It is kind of a combination of geographic and who was federally recognized by CMS
- Sophia: This is more of a suggestion on the data side. It would give us a lot of insight when you do the demo. What is the data telling us when you benchmark against certain counties? This will help us understand where the gap or opportunity is. Given that it is now part of the HIE requirement, the ability to compare and contrast and do different

queries around it. I'd be really interested to see the insight that the data is telling us.
    - John: When I attend conferences with members of CCMCN, their demo does exactly what you are talking about. So it shows what they are getting out of these reports.
- Kevin: One more point of clarification. It is not that these hospitals are not federally certified in some way. For example, the clinics that I operate are CMS certified provider-based clinics, they are just not rural health clinics. The hospital in Alamosa is CMS certified and is a general hospital, not a critical access hospital. So it is not about the fact that they aren't federally certified, it is more about the fact that we didn't include all the possible providers that are federally certified in our state definition.
- KP: I have another question. I am aware of models where providers that sit on the edge of rural communities are doing tele-EMS. They are basically using telehealth to triage the emergency department with folks in rural areas. Do we have those scenarios here in Colorado? And who pays for this?
    - John: There are a couple of different things here. We do have a couple telehealth (for example: Care on Location) providers who are not in our ecosystem but they work with a provider directly. Part of the feedback from our rural providers is that they can't maintain certain types of patients because of this or that. It almost works as if they are the provider.
- Jason: One thing that is going to be fun to see in the demo that our team is going to provide is in the outmigration report it shows how far patients travel for care and what care they received in the local community. You can start to see what is the pattern of patients in a certain community. From a revenue perspective, what revenue could local organizations be losing by care that is happening elsewhere and what opportunities are there for telehealth? Then there is this side of it which is how do you make sure that as much resources are being given to the local communities as possible as the state is providing resources to these organizations. So that is the intent of the out migration report is to paint all of those pictures.

- KP: With that, I'd like to transition to Misgana Tesfaye. Misgana is going to provide an overview of the work in the BITS Division. Over to you, Misgana.
- Misgana: I wanted to update the Commission on some of the work we've been doing at CDHS to create a center of excellence around technology and more specifically around health technology. Business, Information, Technology, and Security (BITS) was formed in late 2020 to bring more accountability for technology initiatives and projects back to the agency and to work with OIT to manage our projects. Since then we have been working hard to establish this team. One of the things we have done is work with our Office of Civic and Forensic Mental Health (OFCMH) formerly the Office of Behavioral Health. With that leadership, we have moved the information management team into a central BITS team. With that move, I've worked with our executive leadership to expand their scope to cover all health facility technology. The BITS evolution from the beginning of the year through the end of the fiscal year, is outlined in the slide presentation. There was a restructure of our Administrative Solutions and we moved our project management team and data operations team to BITS. Colorado Benefits Management System (CBMS) staff was transferred from OIT to BITS in February 2023.

In March 2023, Joint Agency Interoperability (JAI) moved back into the BITS umbrella from our Community Partnerships (CP) team. As of April 2023, all staff transfers/paperwork was finalized through Human Resources. Then there was the OCFMH tech realignment which was completed in July 2023. We recently made an offer to a Data Governance Director and that person will be starting towards the end of November. The next position that I would like to fill is a Health Information Technology Director and that position will be posted in the next week or so. The position description is under review in our HR division. That position will oversee our Information Management team that will look over our EHR systems, data sharing across those systems. Our goal is to share as much data as we can with being compliant. With KP and Stephanie's help, I will be sharing that job posting with the Commission. I would encourage you to pass this job posting across your networks. We would love to have someone in this position who can see the big picture and who can manage our provider data.

- Questions/Comments:
  - Jason: Is the JAI going to create an API layer over state systems so that they can be interoperable together and then with outside systems as well. Is that still the plan?
    - Misgana: We are going back to the Joint Budget Committee (JBC) for additional funding so I can't talk too much about the details. But what we are focused on at this point is helping counties with workflow management as well as document management. We have discovered that we really need to focus on our identity resolution work to make sure we are identifying folks and make sure that those applying for these benefits are identified correctly across the human services systems across the state.
  - KP: I was thinking about OeHI's work and the Social Health Information Exchange (SHIE) and was trying to connect the dots and you did mention identity resolution as one of the categories. Tell me more about how you're thinking about this work turbocharging the SHIE.
    - Misgana: Our main focus is our systems at CDHS want to focus on identity resolution so that counties can deliver these human services seamlessly. That is the identity resolution work we are talking about. I would love to plug into SHIE to see how we can ensure that exchange is also tied in but that is future work. I think that we need to focus on what CDHS focuses on first.
    - Wes: What comes to mind immediately, is access to the benefits management system through provider referral using the SHIE. We are meeting with someone with unmet needs and what would support their well being. We realize that someone might be eligible for benefits they are not currently receiving. How can we sign them up and facilitate that is what we are doing. I do think that, Misgana, you might think that SHIE isn't something that CDHS is actively overseeing but to the extent that you are overseeing benefits I think the SHIE - one thing that they will definitely be doing is trying to sign people up for benefits.
    - Art: I was wondering if you had considered, as you are trying to resolve the identity resolution problem that you described within state agencies, how to leverage all the good work that QHN and Contexture have done in this area to solve identity in their communities. Back to Wes's point, the providers, whether they be

Well Power or one of the CAHs, they all want to get the benefits for their patients aligned and it seems like the identity resolution should be inclusive of these other entities who have 1) worked on it and 2) want to benefit from linkage to whatever is built.
    - Misgana: These are all things that we want to include in these projects. I will say that our mental health EHR is in the process of rolling our seamless exchange and as part of that work, we have to be careful with HIPAA with what we share and we are trying to utilize a lot of that data within our system as well.
- Sophia: Is SHIE a network or are you looking for the SHIE to be a benefit initiator? Even commercial providers, they are not benefit administrators. What is the main function of the SHIE? I'm not sure we talked about what SHIE is or isn't but I think it is a critical question. How much information do you really need SHIE to have?
    - Wes: SHIE is connecting things that exist. These things already exist in the real world.
    - Rachel: I think an example I have heard that has helped me a lot was if you have a pregnant woman and you do a PHQ2 and a PHQ9 and it comes back really elevated. And the PCP in talking to her recognizes that she is housing insecure or she's food insecure - things like that - we will have a tool where that PCP can look up in a system, is she enrolled in WIC? And what else can we do and coordinate with her. Another example would be kids in foster care, they have certain requirements, certain measures, certain benefits they receive - we can make sure that they are not falling through the cracks. While most of the time, they might not even know what benefits they are eligible for. Which puts all the burden on the individual
    - KP: SHIE is basically an enterprise warehouse
    - Gabby Burke (OeHI): With CMS funding, we definitely cannot make the benefits determinations through the system. And that is not going to change. Referring folks to benefits they might be eligible for is something we can do. It will be comprehensive to include trying to get folks hooked up to all different services and support; including things like SNAP and WIC eventually that could provide their full picture of care. It will not be used as a benefits management or determination system.
    - Stephanie: SHIE is a closed loop referral system - it will not be an eligibility system and we will have to work with Medicaid to make sure that all works seamlessly.
    - Kevin: When I hear about the SHIE, I get really excited as a primary care provider for our primary care clinics because it will give our providers access to information to understand the underlying issues the patient may be facing. Either from a micro level or macro level. Many of us, my clinics included, are strengthening our case management where they can get a referral from the physician to help them enroll in other benefits or to address food shortage issues, housing issues - we are all taking on those things more and more because we are understanding better with any kind of chronic disease management. To me, as I

understand it, this is a foundation to really migrate to a value-based payment system instead of the fee for service system that we currently have in place.
- Rachel: How close are we to doing a pilot?
- Gabby: We are so close to executing a pilot. It has been a journey and hopefully in the next ten days, we will have an executed contract. After that execution happens, we will have a more clear timeline that we can share with the Commission.

Public Comment Period

- **N/A**
- **Chat question:**
  - Sara Gallo: Isn't SHIE supposed to aggregate and redistribute out information to account for poor interoperability between platform products
    - Gabby: The answer to this question is yes.

Action Items

KP Yelpaala

- Items to be addressed
- *Next meeting December 13, 2023*

Motion to Adjourn

KP Yelpaala

- KP Yelpaala requests motion to adjourn
- Rachel Dixon motions to adjourn
- Wes Williams seconds the motion