Meeting Minutes

eHealth Commission

October 11, 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, Jason Greer, Sophia Gin, Rachel Dixon, Toni Baruti, Wes Williams, Micah Jones, Art Davidson, Jackie Sievers, Mona Baset, Krystal Morwood, Patrick Gordon, Parrish Steinbrecher, Misgana Tesfaye, Amy Bhikha Absent: Michael Archuleta, Kevin Stansbury

Minutes

Call to Order

KP Yelpaala

- Roll call was taken. 11 voting members present. Quorum Met: YES
- Voting of July Meeting Minutes: YES
- Corrections for July 2023 eHealth Commission meeting minutes?
- Corrections: Spelling of Sophia's name
- In favor of approving: Parrish moved to approve, Art seconded
- Opposed: N/A

- Voting of September Meeting Minutes: YES
- Corrections for September 2023 eHealth Commission meeting minutes?
- Corrections: N/A
- In favor of approving: Art moved to approve, Parrish seconded

Announcements

KP Yelpaala

- We will have a Commissioner Spotlight from Wes Williams and are looking forward to that. We will also hear from Stephanie and Ashley regarding the Colorado Health Innovation Resource Platform (CHIRP)

Stephanie Pugliese

- I will pass it over to Cassi for an update on our request for information

Cassi Niedziela:

- We are excited to announce that OeHI has reopened our Social Determinants of Health (SDOH) service provider Request for Information (RFI). It is currently open and will be open through October 31st at 3pm MT. This is an open opportunity for different technology vendors to provide SDOH services in Colorado to share information about their products and services to organizations who may be delivering or referring clients to those SDOH supports. This information that will be collected from this RFI will be added to our SDOH vendor guide which we currently have out, which is a publicly available resource aimed at promoting transparency in helping clients view services all in one place. Information about how to provide information for this RFI is available in the following document: https://codpa-vss.cloud.cgifederal.com/webapp/PRDVSS2X1/AltSelfService;jsessionid=00007qStpkftMQU02KJ-dIP0n9A:1bpovfs4j If you have currently submitted information in the last iteration of this, you do not have to fill out the form again but if you would like to update the information that is currently displayed for your organization just email our OeHI team email.

This is just for informational purposes. It is not related to our SHIE (Social Health Information Exchange) or any active procurements by the state of Colorado.

Stephanie

- We are planning out our travel for next year around the state and wanted to put a bug in the commission's ears about if you have suggestions that you would like OeHI and/or the Lt. Governor to come visit. Whether those are facilities or your offices or even areas of the state that you've seen a gap in. Feel free to email me or we can set up some time to talk.
    - Rachel Dixon: Have you talked with Kathryn at CCIA (Colorado Commission of Indian Affairs) to discuss some of their work.
    - Stephanie: We are working with CCIA, Serve Colorado, the Disability Coalition, and everyone in the Lt. Governor's office
    - Rachel Dixon: I am also thinking about types of stops where it would be interesting to get a deeper understanding of how eHealth and digital health is functioning in those spaces - Prisons/Jails, psychiatric hospitals, places where there is high eHealth activity, and places where there are big health equity gaps to see what we might be able to learn as a commission
    - Stephanie: Great suggestions - thank you Rachel. Feel free to contact me with other suggestions

Commissioner Updates:

- Misgana Tesfaye: I wanted to update the commission on work that we are doing at CDHS around the Office of Civic and Mental Health and our health facilities in general. That information management team used to be in the Office of Behavioral Health which is now called Office of Civic and Mental Health (OCMH) and has been reorganized to be under the BITS team to create a central information technology group. With that we are also creating an Information Technology Director position which I am hoping will be posted sometime in November. I will be sharing the post that position as we would like the Commission's help to fill that role. It is going to be focused on CDHS wide health technology and electronic health systems. There is going to be a lot of work in that space and programs that CDHS administers but this is the first step in trying to wrangle all of that and to get us to a future state with CDHS.

<u>Commissioner Spotlight</u>: Wes Williams - VP and Chief Information Officer, Wellpower

- Origin Story: Wes Williams
    - Worked my entire career in community mental health (CMHC)
    - Started working while I was still in grad school at the University of Colorado, Boulder working with mental health partners as a child and family therapist
    - 16 years ago switched to work at Wellpower
    - Part of my origin story is defined by the Health Insurance Portability and Accountability Act (HIPAA) security rule. When I started working in the 1990s, everything was on paper and in my experience, there are not a lot of therapists who love technology. I was a therapist who built computers in my spare time but all of my clinical work was done on paper.
        - The HIPAA security rule required all the community mental health centers (CMHCs) as well as healthcare providers to adopt electronic health records for the billing piece. At some level, the medical record part of it was incidental. When we had someone who was being evaluated in an emergency room - we thought, was it appropriate to hospitalize them? We would take the paper chart, put it in a courier envelope, call a cab, and have the cab drive from Longmont to Boulder Community to deliver the chart. That is how we did it.
    - In 2005, I made a shift in my career and moved into helping mental health

partners and then Wellpower implement their first electronic medical records.
    - I've been on the eHealth Commission now for 5 ½ years - I started in 2018 representing mental health interests and have been working particularly on the consent workgroup and how we might share health information, even from organizations like Wellpower, in the context of federal substance use disorder privacy rules.
    - I will also share that as part of my "why" - there is mental illness in my family with both uncles, a parent growing up, and also as a father of a child who has struggled with mental illness - it has been quite a journey. I think that at the beginning of the pandemic, there was all the talk of a mental health crisis. I was able to see the real specific mechanisms of how that worked. Loneliness and isolation the pandemic caused and what it did for child development and I can say that my child is doing fine now and is working with Mile High Youth Corp on their chainsaw crew and couldn't be happier.
- Origin Story: Wellpower
    - Wellpower started because of a class action lawsuit. Ruth Goebel was a woman who suffered from schizophrenia and experienced homelessness in Denver in the late 1970s and early 1980s. In 1981 she, and a number of other plaintiffs, sued Colorado's Department of Institutions who ran the mental health institutes. The premise of the lawsuit was that residents of Northwest Denver were not getting the care that they needed. Part of this was when President Kennedy signed a mental health act back in 1964, it led to a lot of deinstitutionalization and antipsychotics at the time allowed for people experiencing severe and persistent mental illness to be living in the community. Tragically, Ruth Goebel died on the streets - partly due to cold, partly due to exposure, part due to complications from emphysema, and other untreated health conditions. She died in 1983 before the lawsuit was settled. It was eventually decided by the Colorado Supreme Court, in 1998, and it led to the creation of Wellpower the next year in 1999.
    - Denver previously had 4 community mental health centers and there were gaps in the care. Because of the Goebel lawsuit, those 4 centers merged and created a Goebel program. The program ensured that it wasn't just therapy and psychiatry, but we were paying attention to the Social Determinants of Health (SDOH) - does this person have adequate food, how do they receive medical care, do they have transportation? At Wellpower, we have a team dedicated to this kind of work. Right now we have around 2,000 people receiving intensive case management and assistive community treatment services.
    - We do the work that we do because we know that people can and do recover from mental illness. Hope is a big driver. We actually have a hope training that we deliver to every new clinician that comes our way.
    - Last year, we rebranded and became Wellpower. Part of the "why" here is that as we looked around, we found that there was some name confusion and having mental health in the name of our organization was a barrier to care. People thought that they weren't sick like they needed a mental health center and we wanted to meet people where they are. One clear piece of messaging is that everyone can benefit from better wellbeing. Our new brand promise is that we power the pursuit of wellbeing.
    - Wellpower is Denver's community mental health center. We are a safety net provider. We do treatment services but also prevention and crisis services. We see over 22,000 people each year and we have 33 locations. We have 5 outpatient treatment clinics, we have 3 psychosocial rehab facilities, we have a

24/7 crisis walk-in center, we have our behavioral health solutions center, we have 10 residential treatment programs, and the balance of the 33 locations are permanent supportive housing. We also do a lot of work out in the community at nearly 200 additional locations. One of the big models that we are firm believers in is that we need to go beyond the four walls of our clinics and meet people where they are.

- We know that it is really, really hard to have good mental health if you don't have a place to live
    - Wellpower provides 70% of the total residential bed days in Colorado for behavioral health treatment. Between the residential treatment facilities and the permanent supportive housing facilities, we operate over 300 beds.
    - We are a high dose provider. One thing that is different between behavioral health and community mental health as opposed to going in to see a doctor for an infection, is engagement in behavioral health can last a while. Wellpower provided over 50% more units of service than any other behavioral health provider in the state of Colorado. On average, each person served 36 units of service per year which is almost once a week.
    - We had a big shift with Covid and part of this change has been the adoption of telehealth. Having worked on telehealth for almost a decade before that. In February of 2020, we were doing something like 1 telehealth service per day. Now, 3 out of every 5 services we deliver are telehealth services in our outpatient lines of business. For psychotherapy and psychiatry, it is mostly telehealth by choice even though we are open. One thing to mention is that there are several things that people with severe and persistent mental health cannot access technology solutions and what we have learned is that transportation is a bigger barrier than technology. It is really important that we are allowed to audio only telehealth. While the majority of the telehealth we provide is full video 2 out of 5 appointments that we do are audio only and some of that is meeting people where they are and in the way that works for them.
    - We also believe in psychosocial rehab. Our focus is on supportive education and supportive employment. The last time I looked at the statistics, only 1 in 3 people that we serve are employed so two-thirds of the folks are unemployed. When people have a job, it helps with their recovery. We have a supportive employment program that, last year, helped 120 people get competitive employment and stay in those jobs.
- Reminder of what we, as a commission, are working on
    - Three pillars of the Health IT Roadmap
        - Information sharing
        - Access to care
        - Health equity
- At Wellpower
    - Shared data
        - Wellpower is a part 2 provider of all substance use disorder programs. One of our residential treatment facilities, Second Street, is for people with co-occurring mental health and substance use disorders, a medication assisted treatment clinic for people struggling with opioid addiction. We provide specialized substance use disorder treatment. Everyone we treat has a primary mental health diagnosis and it means that we have to follow Part 2 rules. The way we have structured our business is because 1 in 3 people we serve have a substance use disorder

diagnosis. We have not really been able to share health information - we haven't segmented that out which means we have not been able to share health information through our exchanges in my entire time working at Wellpower. We have been a data receiver through CORHIO/Contexture for close to a decade. We have tried and in 2016 there was the Colorado Advanced Interoperability Initiative (CAII). Our piece was about how we can use the framework to share health information through the health information exchange. There were some technical hurdles and it was complicated. We learned some things from the grant. We learned that people would consent to share - people we asked did give permission to share their records with other providers. The most frequent thing we heard was why isn't my provider listed. The grant ended before we were actually able to share any information.

- For 4 years now, we have been up and running with Carequality through our electronic health record (EHR) vendor. The way that works is that there is a common agreement with Carequality that says you follow these rules around that and your organization is listed in their master provider directory and then other organizations can query it. The way that our EHR vendor, Net Smart, has set this up is if we receive a query, then the EHR will check to see if there is a release on file to share information with the organization that is requesting it. If it does find a release it sends out the full release with all the information from Wellpower along with an attached redisclosure prohibition notice that aligns it with Part 2 rules. We have been up and running and sharing data with Denver Health and Children's Hospital. It has been effective but is on a query basis which means someone has to ask for it and it has to be on file. When we first started up and running, three out of every four people that we were sharing with Denver Health hadn't actually signed a release yet. So there was a lot of work to get it to be a useful process.
- The other piece around sharing data is around our experience with Social Health Information Exchange. We have been on the UniteUS network for about 3 years but it hasn't been something that our staff continue to use. We have made fewer referrals than we have licenses on an annual basis. Part of this goes to the question of is this a technology problem. We have case managers who go out and do this work around Social Determinants of Health (SDOH) in the community. We, as a provider, are reimbursed for doing that work and it is effective. We designed the social HIE work for our outpatient clinics who don't have the capacity to do that case management work. When someone really needs case management, we refer them to our case management team and we have people to do that work. All of the work that I was trained to do as a psychologist is less impactful than securing people access to food, shelter, transportation, and safety.

- Access to care
  - Using public health statistics we know that out of every 25 folks, 5 people are experiencing a mental health problem but 3 of those 5 aren't seeking any professional help for it at all. In Denver, you can say that 90,000 people have a mental health problem without access to care right now. Wellpower serves 22,000 people which means we need a fivefold increase in order to close that gap. There is not a workforce that is able to do that. We are a supply side constrained industry. If we had the

money to hire therapists, there aren't enough therapists and psychiatrists out there to hire which means we have to think about doing the work differently. SAMSHA (Substance Abuse and Mental Health Service Administration) funded the program TherapyDirect which is part of Health and Human Services (HHS) at the federal level. They gave us a 2 year grant to get this program up and running. We offer online, on-demand therapy services. Folks go online, click a link, and get connected to an intake coordinator who fills out some of the initial paperwork, gets you set up as someone in our system. You are then sent to a breakout room and a therapist is invited to join and you begin a therapy session. Each person gets limited to three sessions because the fourth session triggers a lot of paperwork. As we near the end of the grant, we have made the business decision to continue this line of business. This program allows us to get people set up within 7 days of first calling us.

- Another partnership that we are proud of is with the Denver Department of Public Safety. We have our co-responder programs where we have around 50 clinical licensed social workers who go out and respond to calls along with the Denver Police Department- and the outcomes have been fantastic. There used to be a 97% arrest rate because the Police saw these calls as just too complicated. That number is now at a 3% arrest rate for those calls. One of the things that Denver should be proud of is that our STAR program provides Denver residents with a mental health problem a first responder option because we have licensed clinical social workers paired with Denver paramedics. 911 dispatch makes this decision as far as knowing that there is no crime involved with this 911 call but it does sound like a mental health issue. So the STAR van gets sent out with no ambulance, no police, no fire and the outcomes have been great. We started a pilot in 2020 with just one van and now we operate in all 7 districts in Denver 7 days a week from 10am until 10pm. This first response option for mental health emergencies is really important and it has really good outcomes.
- We have two brick and mortar options for crisis response. We have a walk-in crisis center that is open 24/7 and is open to anyone in the community who is having a mental health emergency. We have a whole fridge full of food because sometimes people are just hungry. We also recently opened a behavioral health solutions center where first responders can bring folks into us instead of going to an emergency room.

- Health equity
  - We have deployed telehealth kiosks in a number of places throughout Denver in shelters so that people can contact us without having to deal with transportation or other barriers. This is one way that people without devices or internet access can help them leverage in a way that they can get the care that they need.
  - We are committed to anti-racism, in particular anti-Black racism. Our organization as well as the health system as well were all founded in the context of structural racism. So we look at everything through an equity lens through all that we do. What will the impacts be and how will those impacts relate to the most vulnerable folks in different populations? Part of our work in the equity lens is around the SDOH. In my career, I haven't

seen all behavioral health providers think this way. Some folks say things like why are we doing housing, that's not our job - our job is therapy. I don't believe that that helps solve the problem - we need to get to the root causes of inequities that exist. Most of the folks that we serve are on Medicaid or folks who don't have any insurance coverage at all.
    - The other piece of this is that we talk about health equity, it's hard to be a healthcare worker in an environment where the cost of living is so high and we are struggling with this now. When we have payment mechanisms that only increase our rates, we fall behind. In 2021, we implemented a living wage initiative where we now have a $50,000/year minimum wage. We had some peers who nearly doubled their salaries and it made a big material difference in the lives of those people. Temp staffing decreased because since we implemented this minimum wage, we had a lot of applicants.
- Questions for Wes:
    - Matt Bishop: Inspiring work! What does that look like and what technology is involved? Can you talk about referral interoperability both on the clinical care side?
        - Wes: The case management around SDOH - folks rely on 211 which is a resource directory. 211 has an app and our case managers use the app to figure out where to go and get folks the help that they need. That is currently the extent of the technology piece of it. In terms of the actual "doing" piece, it's helping people get connected to food banks or to get a housing voucher into an actual apartment. Helping people step through that process with a persistent and severe mental illness.
    - Mona Baset: I know that you all have really been leveraging technology from a virtual care perspective, which is fantastic, and it's nice to see that those numbers are still high even after the pandemic. Are you finding that other additional technologies are helping you all do your work more efficiently to a broader audience?
        - Wes: That is a good question and the answer is, I don't know. We do have a Wellpower app that is essentially our patient portal and the usage numbers are not fantastic - under 20% of the people we serve are using it. But at the same time, the numbers are higher than they have ever been. We have almost 500 people using it every month and I wish it were more because I think that one of the challenges with telehealth is paperwork and getting things signed. And in behavioral health, we have a lot of things that we need to get signed. In particular, treatment plans which are required by the state. One of the things we are looking at is leveraging these platforms and we are working with Colorado Access right now and figuring that out as part of our new value based contract.
    - Art Davidson: How has telehealth changed the way that you work with NetSmart as a clinician. Have there needed to be changes to the EHR?
        - Wes: Pre-pandemic we used virtual desktops for all of our employees. We definitely had to switch our technology. We had to get everyone laptops and webcams for all of our therapists. We also had to change to a VPN virtual device management. We also had to get everyone two monitors - it was really hard to do telehealth and document on the EHR. The EHR itself did not need to be reconfigured very much.
    - Toni Baruti: You and I sit in the same seat for many different mental health centers. But you have an advantage because you are able to draw from the

inside as a therapist. With all of the data that we need to really look at a client holistically. How do you balance the introduction of new technology with your therapist's understanding that they have constraints with time providing the service of the therapy and them having to learn a new technology. How does your organization balance that?

- You are catching me at a weak moment where I would answer that we are terrible at that. Our staff are burned out. We have been doing employee engagement surveys for almost a decade and the numbers are still good. We have been one of the top workplaces for the last 11 years. Yet our numbers are the lowest they have ever been and they are staying low. We see good clinicians leaving for other opportunities or leaving the field entirely. So people aren't really willing to change at all - even if that is the thing that is killing them - even if the change would be beneficial. It's hard to even recruit people to try it out. It is definitely a struggle.

- Sophia Gin: I'm interested in your comment that this is a supply constrained industry. And I can only imagine that it's only going to get…and I hate to say worse. The need for behavioral health and mental health wellness is only going to increase. How are we as a commission thinking with a longer term view of how we improve the supply side of things? So I am just interested in your thoughts surrounding this.
  - Wes: First of all, I think there are some things that Colorado is doing very well. Such as, it's easier to get licensed here - if you're licensed in another state, there is an expedited process to get licensed in Colorado. In Colorado, we are expanding the number of licensed professionals. In addition, I think there are some movements to do more with peers - people with lived experience with mental health and helping them navigate their journey to recovery. The workforce shortage is a national issue. One of the things that is coming down the pike is that the National Council for Mental Wellbeing has worked with SAMSHA to put forth this certified behavioral health clinic legislation. Currently, only 12 states have this CCBHC (Certified Community Behavioral Health Clinics) structure. But SAMSHA is going to roll out another 10 every two years. Which means it could be a while for Colorado. Colorado applied last year but did not get the grant funding. What it has done in other states is that it allows providers to work on a payment system where we can add in new costs which allows us to pay therapists competitively moving forward and to be able to adjust for things such as 9% inflation and still retain staff and workforce. To get licensed takes a long time and it is not financially compensated in this country.
- Jason Greer: I just wanted to say that I appreciate your leadership and hearing about your origin story as well as the origin story of Wellpower. This was a great presentation
- KP: I second what Jason said and was wondering if you can wrap this up with your thoughts about innovation in healthcare
  - Wes: When I went through the Colorado health innovation community, Monica Vanbuskirk was one of the human centered design coaches and she told me "Fall in love with the problem, not the solution". What that really means is to spend the time to really understand what is going on. Where is the healthcare not working? Only then, think about how can we make this easier? I think a lot of times we say, "I've got a solution. Let's

find some problems to apply it to." And that is backwards. Don't build or sell me a platform and it's hard as we are not equipped to build things ourselves we need to partner with folks who can do that. I think it takes time and that people need to pay attention to how the money works. A lot of times, there is a solution out there that I think can be really helpful and from a health and well-being perspective, it seems like it's the right thing to do. We get paid to do in person, human case management yet we have to pay for these technology solutions that no one is reimbursing us for. I think the money part of the innovation system is really important and worth tending to.

<u>CO Health Innovation Resources Platform (CHIRP)</u>: Stephanie Pugliese, Director, OeHI and Ashley Heathfield, Sr. Project Manager, OeHI

- <u>Stephanie</u>:
  - We are going to keep this really high-level so that we can get to the discussion. A very brief and high-level history of how we got to the need for CHIRP. As we have discussed many times, prior to the Covid-19 pandemic telehealth was really sparsely utilized. The pandemic provided an opportunity for everyone to quickly learn how to use telehealth; both patient and provider. Following the immediate response to the pandemic, in partnership, Prime Health and OeHI stood up Regional Telehealth Learning Collaboratives across the state to understand the process that providers went through to learn telehealth, what gaps continue to exist, what is needed from the state, and any other relevant information. Those went on for about a year and that is also when we did our refresh of the Colorado Health IT Roadmap and really confirmed those findings throughout the stakeholder part of that research. Folks really wanted an agnostic place to have innovation resources focused on telehealth. In 2021 and in 2022, in partnership with Prime, OeHI conducted the provider telehealth surveys. In both of these surveys, that was further confirmed. We really wanted to make sure that this was a need in the community before we would begin the process of what that would possibly look like. Now, this year, Prime Health conducted interviews for stakeholder engagement and feedback to really build out a model of what this resource would look like. That is what we are bringing you today.
- <u>Ashley</u>:
  - Stakeholder engagement that Prime conducted:
    - They surveyed more than 20 providers
    - Met with several state agencies to inform the recommendations and included staff from the Department of Healthcare Policy and Financing, the Department of Public Health and Environment, the Colorado Behavioral Health Administration, and Colorado University's project ECHO
  - Stakeholder feedback:
    - There is a need for a centralized resource center for Health IT and rural health services. Providers specifically stated needs that CHIRP should have including funding opportunities for health IT, state and federal policy updates, state agency communications, networking opportunities. State agencies are also interested in using CHIRP for communication and resource sharing. Stakeholders gave unanimous feedback that a state agency should not own and operate CHIRP as a state resource center

- OeHI's Role in CHIRP would include:
  - Identifying and securing funding for CHIRP
  - Being responsible for the vision, governance, quality standards, and other performance and accountability measures
  - Providing oversight of the vendor selected to operate CHIRP
  - With the chosen vendor, creating an Advisory Board
    - Advisory Board should be
      - A diverse group of experts from different sectors, backgrounds, and regions
      - Providing guidance and support to OeHI to ensure effectiveness of CHIRP
      - Responsibilities will include planning, financial oversight, advocacy, networking, accountability, and evaluation
- Governance will include limiting bias and liability and will have lengthy channels and processes for updating state run websites
- Prime recommends that there is a Request for Proposal (RFP) so that vendors can bid to build and maintain CHIRP with a minimum of a 3 year contract to ensure continuity of the platform. Prime also recommended that the governance of CHIRP be determined through the same RFP process and that it includes an advisory board.
- This can all look like two things: First, the state contracting with one vendor every 3 to 5 years to operate CHIRP and that the state would need to continue to secure funds to sustain the work with the understanding that the vendor will fund CHIRP after a set amount of time.
- Timeline: It is anticipated that it will be 6-9 months after the launch of the RFP and will include gathering and vetting content, hiring staff, and finalizing and launching the website.
- Budget: Prime estimated $355,194 for the build in the first year and ongoing projected costs for year 2 and beyond as $250,113. Costs will include: 3 FTE for operations, website management, and administration. As well as the networking platform, URL and domain name, SSL Certificate, and a web hosting provider.
  - Recommended funding approaches
    - One government agency funds the entire project
    - Seeking annual corporate sponsorships from Colorado organizations and stakeholders
    - Grant opportunities
    - Apply as the regions HRSA designated telehealth resource center

- Questions:
  - Amy Bhikha: Who would own this? When you say that OeHI would facilitate it but not own it
    - Ashley: Right now that is to be determined
  - Art Davidson: Is there a way that you could incorporate more of that specific goal - that problem of telehealth in this recommendation somewhere
    - Stephanie: The focus is entirely on telehealth
  - Krystal Morwood: One of my concerns is when we do vendor relationships, I have a fear where the best interest of Colorado is not always remembered after a long time - has this been talked through at all?
    - Ashley: We haven't really done that as of yet. Where we are at now is really just getting the recommendations. We haven't actually moved forward on anything else. It has been an exploration of what this could

look like.
- Rachel Dixon: In previous conversations with providers, a lot of providers don't know where to go with their training. In the 2021 survey, there were 28 different Colorado organizations offering free training and resources available to Colorado providers. When Prime was surveying a lot of these groups, they also wanted to make sure that all of those resources were being included. This is intended to be a centralized resource hub where you can find all of that information. The other piece we were missing was the centralized funding opportunities. In the surveys you can see, there is data on how providers don't have grant writers or don't have grant managers. Things like even knowing about opportunities for subsidized technology, workforce development, or acting staff, there are a lot of providers who have no idea.
- Q&A Question: Has anyone considered working with the SW Telehealth Resource Center for our state?
  - Ashley: I think that is a really good suggestion and something that Prime had put in there with the grant cycle renewing in August. It would be a good opportunity to explore more closely with the University of Arizona to see if there are opportunities there. I think that would be a pretty strategic thing to do.
- Amy Bhikha: That is a great suggestion. In owning it, what work is actually involved?
  - Ashley: My thought is that it's where it is hosted. It's not necessarily part of the state system but it's something accomplished outside of the state so we can get away with some of the red tape that might exist. Owning it is really managing the content and that is a huge job in and of itself.
  - Art: So is it that it's about knowledge management?
  - Ashley: There were a lot of different resources, especially during the height of the pandemic in terms of information and funding opportunities. This is really like a one-stop-shop for providers in the community. It's an opportunity to coordinate more efficiently in this space. Finding funding opportunities can be really difficult.

Public Comment Period

- **N/A**

Action Items

KP Yelpaala

- *Next meeting November 8, 2023 and will most likely be Hybrid*

eHealth Commission Meeting Closing Remarks

- N/A

Motion to Adjourn

KP Yelpaala

- KP Yelpaala requests motion to adjourn
- Art Davidson motions to adjourn
- Mlsgana Tesfaye seconds the motion
- Meeting adjourned at 1:40PM MST