OeHI
Office of eHealth Innovation

Meeting Minutes

eHealth Commission

February 8, 2023 | 12pm-1:30pm | Hybrid Meeting

Type of Meeting	Monthly eHealth Commission Meeting
Facilitator	KP Yelpaala, *eHealth Commission Chair*
Note Taker	Amanda Malloy
Time Keeper	Amanda Malloy
Commission Attendees	Michael Arhculeta, Toni Baruti , Amy Bhikha, Art Davidson, Rachel Dixon, Patrick Gordon, Micah Jones, Jackie Seavers, Parrish Steinbrecher, Misgana Tesfaye, Wes Willams, KP Yelpaala, Jason Greer
Absent	Sofia Gin, Kevin Stansbury, MS, JD, FACHE , Mona Baset

Minutes

Call to Order

KP Yelpaala

- Roll call was taken. 9 voting members present. Quorum Met: No
- Voting of Meeting Minutes: N/A
- Corrections: N/A
- In favor of approving: N/A
- Opposed: N/A

Announcements

- A number of Commissioners are awaiting official reappointment and are technically not voting members for this meeting
- By next month, all of our Commissioners will be reappointed. We will vote on approving meeting minutes and any other votes next month

Stephanie Pugliese

- We submitted our response to the federal proposed rules on the Confidentiality of Substance Use Disorder (SUD) Patient Records
- Submitted on behalf of OeHI, the eHealth Commission, and a number of our State agencies at the end of January
- We will have another opportunity for rules, comments, submissions that is due in March 2023 and that is for our upcoming interoperability rule. These will begin to be drafted in the next week or two and we will send those out for Commission review and input later this month.
- Art Davidson requested an update regarding the Social Health Information Exchange (SHIE) procurement:
    - Stephanie's Response: SHIE procurement opportunity also closed at the end of January; we received 6 submissions and are eagerly reviewing them now. We will keep the Commission updated as this progresses
- No Commissioner updates at this time

Agenda Item-MAIN SPEAKERS

Speaker: Toni Baruti

- All Health Network has a shared vision with the State to provide digital inclusion and digital health equity to all Coloradans
- We have taken the learnings from the Commission and implemented them into our

processes and infrastructure
- Presentations from the eHealth Commission and Care Coordination teams have been taken back to All Health Network to make sure we are doing the same things so that we are aligned with these efforts
- Roadmap slides shared to show where we are and where we are going as far as healthcare and equity including virtual and remote services
- All Health has been focusing on operationalizing this work when it comes to the core information services - data sharing management, scalable data sharing platform, and social determinants of health
- Toni, as a commissioner, is pushing this information out to All Health by:
    - Participating in the Colorado Health Innovation Community (CHIC) project
    - Participants receive training, frameworks, skill building and peer learning on the following:
        - Operationalizing health equity
        - Identifying and addressing health disparities
        - Human Centered design
        - Sustainable and scalable health innovation
    - All Health is standardizing all systems and forms to utilize the most inclusive categories for race, ethnicity, gender, sexual orientation, and disability
        - Currently focused on race and ethnicity
        - The AMA came and spoke with All Health about the barriers regarding race because a lot of times 30% of the population will be in the “other” category and being able to minimize this by expanding the race categories
        - All Health has started a state of the art Health Equity training developed by national leaders
- All Health has integrated tools to address health inequities. They are partnering with Gray Matter Analytics (Black women owned business) and implementing solutions with incorporates Social Determinants of Health which will enable All Health to quickly access VBC (Value Based Care) to identify members and/or patients at risk and to improve health and well being outcomes
- All Health has implemented a post-service tracking and monitoring team that follows up and monitors clients - especially those who have received acute care services
- Data Structure: designing infrastructure to ensure interoperability for ease of data sharing
    - Making sure staff has a good understanding of health disparities and health equity by designing the infrastructure to bring all of this data in and to make sure they are inclusive of their demographic data
        - Current state of data structure
            - Reduces manual effort to run Structured Query Language (SQL) in silos
            - Efforts towards building Enterprise Data Warehouse and analytics will start to pay off
            - Helps run the project in agile mode
            - Gives leverage to change to better direction as they keep moving forward
        - Future state of data structure
            - Data will be extracted from various sources using extract, transform, and load
            - Jobs will be run in a batch mode to update Enterprise Data Warehouse and Data Marts

        - Well built Enterprise Data Warehouse can support self service and a strong BI layer
        - Operational Data Store , Enterprise Data Warehouse, Data Marts, and BI Tools will help businesses make better decisions
- Standardization and collaboration between stakeholders and community partners is what is needed to make this All Health project successful
    - Standardizing data sets
    - Treating the whole person
    - Goal is to have the State to all be on the same page
- All Health hopes to be the most impactful growth and recovery provider with communities most in need

Questions for Toni:

- **Wes Williams:** People we serve do not understand having separate dimensions of race and ethnicity - they are not separate constructs - WellPower has deconstructed those two fields into one long multi select way. They have the same categories but then, the way they translate that into State data submission - sometimes they answer the race question but not the ethnicity question and vice versa. If they select multiple things, then they end up choosing one or more or other. Their project identified a mismatch between how people see and think about themselves. How is All Health approaching this and other decisions All Health may have made around this issue?
    - **Toni:** All Health tried to come up with the most inclusive list that would make sense to our clients and when you talk about race and ethnicity and where people categorize themselves, that is a whole other subject matter and what race means as far as just America as a country - and where Black and White race comes from. This is the easiest way to simplify it to really get the information that we need to be able to close the gaps of health disparities
    - **Wes:** The way this was presented makes sense about how people see themselves. From a data select standpoint, it makes sense to have a multi-select form where they can choose all that apply. Data needs to be reported to a State system through the BHA, who then passes it along to the Feds and we are not thinking about race and ethnicity in the same way - they aren't asking us to submit it in the same way. What is All Health doing with that?
    - **Toni:** All Health is not currently collecting it in this way - this is what the American Medical Association (AMA) is suggesting to have more inclusive lists because we are missing out on certain populations and these populations are falling through the gaps. As a Commission, it is our responsibility to push this up to folks at the State level and say the current categories that you all are using are not inclusive and excluding these groups of people and they may be falling through the cracks. We need to push it up and make it known so that those changes can be made at the State level or the health disparities are going to stay the same or widen
    - **KP:** The Feds know this is an issue and from an organizational level, this is a framework for what should happen; organizations should be held accountable for collecting richer data and then you can make sure that it is the way you need it reported. No one is one category and it impacts how they self-report. There is also a generational element - it also looks different. The way this is being framed is sound and it is appreciated to have been brought up
    - **Wes:** Another question for Toni: You mentioned Gray Matter, who is giving you value based payments?

    - **Toni:** This is being proactive for what could happen and where the climate and industry is going
- **Art Davidson:** You mentioned Care Coordination and trying to take lessons from that group. How are you connecting with primary care around your clients and are these HL7 tools that you're using as source systems. How are you thinking about the interoperability regarding Care Coordination?
    - **Toni:** The slide lists the transactional systems within our organization. We work with CORHIO but haven't integrated any of that data yet into our data warehouse as this is our future state; all data sources will go into this future state. Then we are hoping for strategic planning for their organization and their partnerships as primary health is concerned and integrated care. We are starting to widen our partnerships and looking at what partnerships have we not tapped into that treat the whole person. Once we have those partnerships, we are able to share that data within the enterprise warehouse.
- **Rachel Dixon:** When working with providers, especially smaller providers, how do we even ask the questions? In the LGBTQ+ space, how do we ask about their sexual orientation, gender identity, and do we force them to disclose or not disclose - same with race and ethnicity. And I wonder if that is an early opportunity for this Commission to put out principles and guidelines that have been established
    - **Toni:** A lot of times, it is a hard conversation for our intake staff and that is why we started health equity training with our board, technology, and finance teams. Everyone in our organization has been trained on health equity. And there is additional training with our frontline staff that are doing intakes. They have indicated that sometimes they will make a guess at what someone's race is. Training them on how to ask and letting them know that providing this information helps us get them the best care possible. If they understand why those questions are being asked, they will most likely be able to give us the information. But you have to train the staff on how to ask these questions.
    - **Wes:** For the people we serve that are transgender, being able to have us address them with their name and pronouns, rather than what might be on a birth certificate is really important. What is the role of the health information exchanges in getting up to speed with being able to share health information so that all Coloradans providers have the information about pronouns, preferred name, gender identity that makes them feel at home and included at their healthcare providers?
    - **Toni:** One thing that All Health is doing is making sure that we have a very diverse workforce. When they walk into those providers and see someone who looks like them, that understands them, and has that same shared experience, the walls go down and they are more apt to give that information because they see that they are coming to a healthcare provider that is inclusive. It gives them the feeling that this is a safe space - this place really cares about me and my well-being
    - **Micah:** It is important to come up with a model that helps Colorado. There are many hoops we have to jump through to make this successful. One important thing is the input of the data in the EHRs. With Health Information Exchanges, our data sources are electronic health records. One of the things we have found is that demographic data is entered inconsistently across EHRs and even within organizations. One of the things we have learned in other States as well is that some states do tie the electronic health data consistently. With that said, once you get beyond that aspect of it, it's my understanding that most of the systems will require some updates to their systems to get to some of the more updated

things like transgender to get up to that capability where you're getting enough data. I think that the trick is to facilitate at the EHR level to actually get that data into an HIE. At Contexture, specifically, we use another identity program called Verato which allows us to input additional data elements
    - **Jason**: One thing that I love is that we don't wait for standards. When it comes to integrating systems, I would love to know how we all get connected? What would be the way that we work with All Health Network so that the systems we are working with today can contribute to each other?
    - **Toni**: With the Behavioral Health Center- we now have a monthly meeting where we are making sure that we are staying aligned. If we keep the lines of communication open, meeting regularly, and are sharing ideas, breaking down any silos, and really keeping the Coloradan client at the center, I think that is how we collectively work together. I'm interested in seeing the list that Wes uses. Is there State funding to help push these initiatives? To come up with a solution, let's come together and see how we can utilize these things to help all Coloradans.

Speaker: Misgana Tesfaye

- Business Innovation, Technology & Services Division Director at CO Dept of Human Services (CDHS)
- Created the first data mining/scoring system for state tax audit selection while he was at the Department of Revenue. Also spearheaded paperless audit environment for the Department of Revenue
- CDHS:
    - Mission: Together, we empower Coloradans to thrive
    - Vision: To serve Coloradans through bold and innovative health and human services
    - Values: A people first approach, balance creates Quality of life, holding ourselves accountable, transparency matters, we are ethical, collaboration helps us rise together
- Our team has around 4,619 employees across the State and over 60% work in Direct Care
- BITS
    - Mission: We deliver transformative business and technological solutions for solutions for CDHS programs and partners that empower
    - Vision: BITS will be the premiere strategic partner in delivering
    - Values: Ethical, Innovation, Balance, Purpose
- Connections with the Colorado Health IT Roadmap
    - BITS actively pushing for State ID resolution modernization as the first step to interoperability
    - Actively modernizing outdated databases within CDHS in order to better access and operationalize data
    - Working closely with the Joint Agency Interoperability (JAI) project to ensure success
    - Considering a "Health Technology Product Owner" role that would coordinate efforts agency wide
- **KP:** It's nice to see the work laid out that way and all of the work you are doing - any questions for Misgana?
    - **Jason:** Thank you for your work on the tax functions in Colorado. You mentioned something about a community partnerships division of CDHS - I am

curious more about what that is. Also, are you looking at moving CDHS into a cloud system when it comes to data management?
    - Misgana: To start, community partnerships is a group that has existed in CDHS (and I can connect you with those folks) for some time and they interface with counties and local jurisdictions in general to oversee the interoperability project. If the Commission wants to get in touch with those folks, I will connect you. In regards to the big picture and getting Google on board or using applications that are opened up or that are allowed to be opened up according to HIPAA, that is absolutely the goal. We want to share as much data as we can while protecting Coloradans privacy. We do have a privacy officer that works specifically on HIPAA.
  - **Art:** I was trying to understand the relationship between CDHS and the counties and you touched on that in the last discussion. I am wondering more about interoperability - for CDHS, talking with those county agencies, is there a method or a standard method across the country or in-state that each partner would share information
    - **Misgana:** I will try to get my terminology correct - Colorado is a state administered county-run health services environment so it's quite whispery because it depends on what level of services the county requires from the state. There are some counties that do not require much service and are very independent and some counties that do require more state assistance. With that gamut of county reliance on state infrastructure, you have different levels of service. JAI is trying to consolidate this into one system so that all counties can interface with it.That is the goal of JAI is to have one system of interoperability that all counties can use and be on the same page.
  - **Art:** Have the more advanced counties bought into this vision?
    - **Misgana:** Yes. There was a vote on the county auxiliary system and there was a vote and a general consensus that we need to get on the same page, but the solution has not been identified as of yet

- **Consent Management Workgroup:**
  - **Wes**: The consent workgroup has been on hiatus for almost a year and a half and we were looking at how we can share BH data that is covered under 42-CFR Part 2 (substance use disorder privacy regulations). From a technology perspective, if you came up with a solution that can handle Part 2, it would also handle a lot of the social health information exchange data from healthcare providers to community based organizations. But the consent workgroup has really been focused on those things. People have been really hopeful that this would be solved from a policy perspective - such as the rules would just go away. The new rules that OeHI just commented on are evidence that this is not going to happen. And won't happen for an important reason - people with substance use disorders have trouble obtaining care already and privacy protections are super important so that we can get people the care we need. Especially as our country has shifted to really recognizing that substance use disorders are an illness and not a character flaw. In the time since the consent workgroups meeting, I know that Melissa and Craig have been working on a couple of different work streams - one around getting a standardized consent form across the State that different providers can adopt and use. The work has progressed enough that it makes sense to reconvene the workgroup.

- **Craig Kim, OeHI**: Our very first meeting will occur on February 17th and it is to tackle exactly what Wes has mentioned which are our substance use disorder cases. So with that, we are also in the process of drafting a charter to get that charter out to certain workgroup members to review the comment to provide feedback on and at the end of the day finding out what is important to that buy-in. We would love for you to join us. In addition to that we will also have Cassi presenting on the health equity approach to consent management. We are working with OIT to look at a pilot solution regarding consent management within the substance use disorder cases and they are currently working on those requirements with us.
  - Micah: Will this be the same workgroup or will it be comprised of new members?
  - Craig: It is going to be comprised of new members
  - Stephanie: The meetings will be public so anyone can join us

Comments on Presentation

Public Comment Period: No public comments

Action Items

KP Yelpaala

- *Next meeting: Wednesday, March 8, 2023 - will be Virtual*

eHealth Commission Meeting Closing Remarks

- KP: This has been a really good meeting

Motion to Adjourn

KP Yelpaala

- KP Yelpaala requests motion to adjourn 13:37 MST
- Rachel Dixon motions to adjourn
- Amy seconds the motion
- Meeting adjourned at 13:38 PM MST