OeHI Office of eHealth Innovation

# Meeting Minutes

## eHealth Commission

*July 11th, 2018 | 12:00pm to 2:00pm | 303 E 17th St. Rm 11ABC*

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| Type of Meeting | Monthly Commission Meeting |
| Facilitator | Chair Michelle Mills |
| Note Taker | Jessica Yan |
| Timekeeper | |
| Commission Attendees | Michele Lueck, Chris Wells, Marc Lassaux, Sarah Nelson, Carrie Paykoc, Michelle Mills, Mary Anne Leach, Chris Underwood, Justin Wheeler, Wes Williams, Adam Brown (On the Phone), Ann Boyer (On the Phone), Jon Gottsegen (On the Phone) |

## Minutes

### Call to Order

- Michelle Mills called the meeting to order as Chair of the eHealth Commission

Approval of Minutes

- Attendance does not constitute quorum,
- Minutes were approved for April, May, and June.

Review of Agenda

- Michelle Mills, Chair

### Announcements

**OeHI Updates**

- OeHI Updates – Carrie Paykoc
  - New intern- Jessica Yan is an Informatics Student at CU Boulder and is working on compiling a list of health policies passed in the past years.
  - Second OeHI Connects Newsletter was released. Reached 602 individuals. Encourage you to get people signed up and get involved with OeHI.
    - Spotlight an eHealth Commissioner every month.
    - Three most popular links in the road map was the eHealth Commission, Health IT Roadmap, and the JVC Funding.
  - HB18-98 requires states commissions and boards to follow best practices. No funding for boards and commissions office. Members should have received the new Sunshine Rules and best practices. Working with HCPF and CDHS to develop new trainings.
    - Trainings need to include goals of the commission, quorum, conflicts of interests, CORA, duties, and onboarding. More details will follow.
    - Mary Anne: We will want to finalize our bylaws as we work towards best practices for state commission and boards.
- OeHI Updates – Mary Anne Leach
  - PRIME Health – Looking for critical access hospital innovation opportunities, because rural hospitals are shortest staffed. If those hospitals are working on projects that relate to our goals, we could align these efforts with our office.
    - Nicole: Have 150k to fund pilots in rural areas. This would be available to critical access hospitals, safety net institutions and public health

offices.
  - OeHI operating budget is being finalized for fiscal year 19-20. Looking to codify the office and appropriate funding for the office.
  - Policy Proposals- Looking to develop drafts in anticipation of next legislative session. We would love your thoughts on these.
    - One suggestion is making all information related to prescriptions available in HIEs. Foster better data sharing across the state.
    - Justin: Would that be medication lists, or pharmacy data on possession?
      - Mary Anne Leach: Yes, both. There is interest because of opioids.
      - Justin: With people with chronic conditions, it's important to note if patients are receiving 30/90-day supplies, seeing specialists, etc. It's important to see all prescriptions from a primary care perspective.
- Other Updates: Marc Lassaux
  - CORHIO and QHN, with help from HCPF, enabled a pilot to allow access to PDMPs through HIEs. Great feedback from ER Docs in pilot. Gives physicians a good sense of patient behavior.
    - Mary Anne Leach: We're looking at different price points to expand this statewide. Expensive now, since currently cost is now price per user per year. Looking to get a cheaper deal, with group purchasing price. We're working with Apres, but it is slow. Critical to fighting opioid crisis
- Other Updates: Jon Gottsegen
  - In the fall, we're looking to host a 2-day Analytics Challenge where we analyze how open public data can be used innovatively to help agencies think about their data. We're looking at 3 different subject areas including Opioids and Marijuana. It will be a data summit- a small cadre of agencies in a room together thinking about data sharing challenges, and data governance issues.
    - Wes Williams: What publicly available data sources are available regarding opioids?
      - Jon: Not that much. We want to look at public, but non-discoverable data. This will provide motivation to make those things more available.
      - Wes: I'm not sure what information would be available for opioids besides deaths.
      - Jon: Right. I think we should think about how we can logistically run this. Many people would like to see this data, so we need to locate this data and make it more available.
    - Carrie: The dates for this will be the second or third week of September.

## New Business

**Information Security Part 1: NIST, GDPR- David Ginsberg, President, PrivaPlan Associates Inc.**

- David: Regulatory Environment for Cyber Security
  - HIPAA enforcement has become aggressive and costly due to major law changes.
  - HB18-1128 – Affects all Colorado businesses and extends HIPAA definition of covered entity to virtually all corporate entities.
    - Expands PHI data elements to include combinations of email, username and passwords and security questions.
- EU GDPR

- EU has had substantive laws, but now they are upgraded to emphasize digital environments rather than privacy of data.
- HIPAA Differs from GDPR, which is used in the EU and the rest of the world.
  - GDPR includes the Right to be forgotten- Data Erasure
  - GDPR Data Protection Officer = Security Official in HIPAA due to different terminology
  - GDPR Data Controller= HIPAA Covered Entities.
  - GDPR opt in consent vs HIPAA opt out
  - Pseudonymization in GDPR is known in HIPAA as Deidentification
- GPR introduces idea of privacy by design, which is building security protections into the software. HIPAA is out of date
  - ONC referred to this in the 2015 Addition of Certified eHealth Technology. Create stronger more granular protections for individuals.
  - Difficult to plan data governance if there is no existing infrastructure.
- GDPR applies limitedly to US companies.
  - Companies selling stuff to EU must be GDPR compliant.
  - However, with most cases, even with EU patients, GDPR doesn't apply.

- Other places like in Canada, Chile, Japan, and South American, have EU style laws.
- US Standard Setting- NIST
  - NIST is a government funded agency that make standards for commercial and scientific organizations.
  - Published special publications in information security which are cited within HIPAA security regulations.
  - Important sections
    - NIST SP 800-53 promotes privacy by design. Emphasizes idea of identity access management rather than just passwords.
    - NIST Cyber Security Framework- overview of compliance standards, including asset management, risk management, identity management
- Colorado Healthcare and Cybersecurity Report Card
  - Need emphasis on improving business associate management, termination management, social engineering
- Wes Williams: Consumers have a right to be forgotten but record retention is important, and information is a valuable business asset. How do you see people balancing those considerations? What are providers doing- destroying or obscuring the information?
  - David- This speaks to issue of data governance. Data can be shared and found in many places, like COHRIO. We also need data to maintain continuity of care. Huge contradiction between right to be forgotten and data needed for medical care. My perspective is that we cannot delete EHR data.
  - Mary Anne: In Colorado, EHRs need to be retained 10 years after age of majority, so seven years.
  - David- There are other regulations for people exposed to asbestos or other cases, for longer periods. These laws are archaic.
  - Mary Anne: The challenge is that most health organizations retain everything forever. It's a huge risk.
  - Justin: Feasibly, it may not be possible to delete stuff. Maybe we can obscure data to retain the data. I wonder what are people doing?
  - Mary Anne: Our vendors need to develop the capability to delete/obscure data. GDPR may more traction as more people want the Right to be Forgotten.

**Information Security Part 2: HITRUST, Organizational Readiness- Trent Hein, Co- Founder and Former CEO, AppliedTrust**

- Data privacy is so important, as it increases our convenience and quality of care for patients, but it also increases the risk and responsibility to handle data safely.
- We must protect Confidentiality, Integrity, and Availability of data.
- Why cyber security? Regulation isn't the only reason why we care about cyber security. We also care about cost, compliance, public image, ethics and that everyone else is doing it.
- No organization has all the resources to make everything perfectly secure.
- Likelihood and impact analysis lists possible events, likelihood, and impact. Gives toolset to focus resources
- Many Healthcare cybersecurity opportunities with the internet of medical things.
- Challenges
    - Users – All technological approaches can be taken, but if users aren't aware of responsibility, there is risk. Users must be aware, trained, and given the right leadership.
    - Biomed/IoMT- Internet of Medical things. Devices handle sensitive PHI. Must manage vendors and maintenance of devices.
    - Must prioritize funding of cybersecurity.
- Many Standards for Cybersecurity. This includes ISO 27001 and 27002, Common Criteria, COBIT internationally, and HIPAA, PCI DSS, NERC CIP, Privacy, GDPR, US State regulations domestically.
- HITRUST- Nonprofit alliance of interested healthcare parties made one standard for cybersecurity. This is free to providers and is prescriptive/comprehensive.
    - Can become certified (expensive) or can also do a self-assessment with no outside validation.
    - CSF domains – areas that HITRUST applies rules to increase security.
    - HITRUST recommendations – HITRUST is huge, not a good starting standard. Use NIST or something else first.
- Always ask why. Need the right culture and leadership.
- Practically, know the why, create a framework, prioritize efforts, know your environment, and create culture at the top.
- Ensure you have cybersecurity incident response plan and drills and join an ISAC. (Information Sharing and Analysis Centers)
- Mary Anne: How often should organizations do a risk assessment or penetration test?
    - Trent: At least annually. If you have internet exposed services, which are customized, they will have more vulnerability. You should run a base scan every 30 days, and a penetration test every 6-12 months.
- Justin: For providers that are small: How can they have cybersecurity with small budgets?
    - Trent: I think there's an opportunity for this commission to provide a standard packet of tools, like scanning and firewall services, to provide that will make it more affordable. About 4% of overall IT budgets should be spent on cybersecurity.
- Mary Anne: The demand for 11k cybersecurity professionals in Denver is disturbing.
    - Trent: Yes, it is terrifying, as there is a huge gap and lack of educated individuals.
    - Mary Anne: Is there something that we can do to promote jobs in cybersecurity,

like internships?
    - Trent: Yes, Governor Hickenlooper has done a great job at cultivating cybersecurity professionals in higher education. Unfortunately, it takes time to educate people.
    - Michelle: Now, many community colleges are offering IT degrees and careers.
- Mary Anne: Do you think it would be possible to create a one to two-page document about cybersecurity for our rural health centers?
    - Trent: Yes, we can.
    - Mary Anne: This is something we should do with OeHI.
- Marc Lassaux- Two thoughts: Does GDPR apply to American providers who treat people from the EU? Secondly, these HITRUST projects are extremely expensive. How can we tackle and minimize these costs?
    - Mary Anne: We can have subsidized projects.
    - Trent: Many CIO's thought the cost overshadowed the benefits of HITRUST. Secondly, one element that would be helpful is a multiyear roadmap, so these costs don't seem overwhelming.
    - Mary Anne: It's important always to ask why. The GDPR question is interesting, as we haven't even been able to focus enough on HIPAA, which is our priority. However, there are cases where there may be a breach without GDPR. We will need to have ongoing conversations.
- Mark: Can the commission make resources available to organizations who need help with cybersecurity?
    - Mary Anne: We can. We haven't funded this roadmap initiative yet, because we focused on the 90/10 HITECH meaningful use dollars, but it may be worthwhile to have a pool of dollars for education for webinars, trainings, for organizations. Funding our own cyber center.
- Justin: My understanding of meaningful use is that you're required to perform a security audit. How do you interpret the security assessment and what information you've given, to prioritize it? Many organizations may be receiving this information, but not interpreting it correctly.
    - Michelle: We are offering, through David, a HIPAA certification program. It doesn't replace the audit but helps organizations to reduce audit costs.
- Michele: Is scale an opportunity to bring down costs? Is it possible to offer a package of services to rural hospitals or mental health centers to reduce costs?
    - Trent: Yes, it is much easier to have standard regulations and lower costs. The more we can group together smaller organizations, the better.
    - Michelle: Note that we have been doing this since 2012 where we offer group purchasing for services for rural health centers.
    - Michele: We could scale this up.
    - Trent: A group of organizations would have to agree on priorities, frameworks.
    - Mary Anne: Could we use Meaningful Use dollars to fund some of this? I will contact Kim and Micah to look up some of those rules related to HITECH funding to see if there is a link to cybersecurity.

**Health IT Roadmap: Six Month Progress Report- Mary Anne Leach, Director, Office of eHealth Innovation, Carrie Paykoc, State Health IT Coordinator**

- Administrative Level- Increased Roadmap communications, talked at conferences, and distributed many digital and hard copies. More work to do to get the word out to align healthcare organizations.

- Funding- We've gotten 10% of the 90/10 funding, but still waiting for CMS funding. We will know by late August or September. Submitting operating budget for 19/20, which is 2.4 million.
    - 40 million in capital and operating funds through 2021
    - Positive conference calls with CMS.
- Governance- Have 3 workgroups- Care Coordination Workgroup, HIE and Data Sharing Workgroup, Consumer Engagement Workgroup. Care Coordination group started a core group that will be expanded. Consumer Engagement Workgroup is starting to form soon.
- Roadmap Progress
    - 1) Care Coordination- Did a survey and identified opportunities, like creating a connected marketplace for health organizations, like BoulderConnect. This could be useful for referrals. Workgroup will help us scope this out.
    - 2) Consumer Engagement- 9News and OeHI did a consumer survey. We hope to have Mosaica Partners to use our Roadmap methodology to understand needs and wants from consumers to create recommendations and requirements. We have about 1.35 million to spend on this initiative.
    - 3) Advance HIE and Data sharing. Both HIE's are actively integrating PDMP and social determinants of health information. Carrie has been working with state agencies and counties to advance data sharing.
        - Carrie: The Colorado Evaluation and Action Lab, at DU Policy, partnered with the Governor's Office to help state government to share data to inform better practices. One practice is a partnership with Jon Gottsegen to set up processes to share data. The hope is to scale this for Case Management and other partners.
    - 6) Health IT Portfolio/Program Management- We've had conversations with OIT and HTS. Hired first program manager – Ako Quammie. He is looking to consolidate EHR systems to one or two systems. Small EHR programs may not exist in a few years, so we want to consolidate HER.
    - 11) Digital Health Innovation: Partnered with Prime Health and 10.10.10. Hosted 2 Summits. Both organizations aligned their programs with Roadmap. Carrie and I have been connecting innovators with important contacts and align them with our initiatives.
    - 13) Ease Quality Reporting Burden- We've starting this work with SIM.
        - Carrie: SIM effort is moving forward with QHN and CCMCN and COHRIO, with the Colorado Health Institute leading the work. There is a data governance committee forming. As SIM sunsets in 2019, we will transition what OeHI will take over and evaluate the program. There are elements of Blockchain in this.
        - Mary Anne: The approach is to have SIM pilot these ECQNs, and us Roadmap funding to scale this and make this a sustainable business model.
        - Justin: Some of those stakeholders are CHITAs. Do some of these initiatives have overlaps with APMS?
            - Carrie Paykoc: There is an overlap with APM. With the CHITA, QHN, CCMCN and COHRIO are providing that safety net cheetah role. We will evaluate the CHITA Support. It specifically medicates APM models and works closely with SIM
        - Justin: So much overlap, having continuity is valuable. Seems achievable.

- 14: Unique Person Identification- Furthest along, started before commission existed.
    - Issued RFI on the MPI and got public comments and drilled down on focused problems to self.
    - Lead us to SIDMOD, the Medicaid number, and downstream identifier. Discovered that SIDOD was written in 1984. It is creating IDs, but we aren't doing a good job at automating and reconciling it. 15-20k IDs generated every month, with 1.4 million Medicaid clients total. Inefficacies of getting unique person. Using a common identifier to link DHS can link social determinants of data.
    - Justin: What is MDM?
    - Mary Anne: MDM means master data management but has many different definitions.
    - Currently, we are evaluating Verato opportunities.
- 15) Unique Provider Identification- CHDPHE is making good progress in provider directory. May be able to fund this effort eventually.
- 16) Broadband and Virtual Care- Much work to be done. Delegated to Office of Broadband. Neil Anthony Grace has done a great job doing this.
    - Governor signed a bill for 100 million for funding in rural underserved area. Great progress, but we need 850 million.
    - Justin: How does that this bill fit into the CTN?
        - Mary Ann: When CTN was created, its intention was to be a dedicated medical-grade network. But now we have the internet. CTN will need to have a competitive price point to compete.
        - Justin: I've heard that talk that that the expansion of Broadband into rural areas that drove CTN in the first place was done enough so it wasn't clear enough that CTN needed to exist in the future.
        - Mary Anne: I think they took on both charters, including Telehealth and Broadband. Original funding came from FCC grants.
        - Wes: I'm just curious because I'm seeing funding for similar things. I'm wondering how they fit together in the state infrastructure.
        - Mary Anne: It is interesting; we should put this on a future agenda. Additionally, we should have health centers doing innovative things come talk to us, so we can support them.
        - Michelle: I love that idea. Some of the issues have to do with the number of providers and not necessarily the technology. That conversation should be helpful.

**Public Comment**

1) Public Comments – none.
2) Closing Remarks – none.
3) Meeting adjourned.