OeHI
Office of eHealth Innovation
eHealth Commission

Meeting Minutes

May 11, 2022 | 12:00pm - 2:00pm | Virtual Meeting Only

Type of Meeting	Monthly eHealth Commission Meeting
Facilitator	Kaakpema "KP" Yelpaala, ***eHealth Commission Chair***
Note Taker	Cierra Childs
Timekeeper	Ashley Heathfield
Commission Attendees	Wes Williams;Amy Bihka; Chris Wells;Jason Greer, Jackie Sievers, KP Yelpaala, Rachel Dixon, Sophia Gin, Toni Baruti, Micah Jones, Arthur Davidson, Absent: Kevin Stansbury; Parrish Steinbrecher, Patrick Gordon, Mona Baset, Michael Archuleta

Minutes

Call to Order

Kaakpema "KP" Yelpaala, *eHealth Commission Chair*

- Roll call was taken. 11 present. Quorum reached
- Toni Baruti motions to approve the April 2022 eHealth Commission meeting minutes
- Chris Wells seconds the motion
- Corrections: None
- In favor of approving: Unanimous Aye
- Opposed: None

Announcements

Stephanie Pugliese, *Director, Office of eHealth Innovation (OeHI)*

- OeHI Updates - eHealth commission Updates
  - John Kennedy is our newest project manager focused on rural connectivity
  - OeHI sent out an announcement for our RFA for Telehealth and Broadband, an opportunity for rural service providers to access devices and increase bandwidth for telehealth
  - Additional partner opportunities coming in the coming months
- Commissioner Updates
  - Wes Williams - Mental Health Center in Denver has changed its name to "WellPower"
  - Programming has evolved over the years, and this name better reflects breadth and depth of services and connection between mental health and overall wellbeing

Presentation

- KP introduces Dr. Chris Gibbons:
  - Dr. Gibbons is the founder and CEO of the Greystone Group, a digital health innovation and transformation business, chief health and innovation advisor at the FCC, and previously associate director at the John Hopkins Urban Health Institute and Assistant Professor of Medicine, Public Health, and Health Informatics at John Hopkins
  - Has insight on the health equity space
- Dr. Gibbons: Introducing *In Full Health: A Learning & Action Community to Advance Equitable Health Innovation*
  - AMA created Vice President of Equity two or three years ago, and began focusing on equity.
  - Put together AMA strategic plan for equity
    - Five strategies for addressing health equity
      - Embed equity in everything
      - Build alliances and share power with marginalized communities
      - Ensure equity in the health innovation space - focus of talk
      - Push upstream

            - Foster trust, reconciliation, racial healing, and transformation
    - AMA vision - Prioritize resource allocation to launch and scale solutions that are meaningfully advancing health equity
    - Four objectives
        - Center marginalized innovators, investors, patients
        - Embed equity within existing AMA innovation efforts
        - Engage in cross-sector collaboration and advocacy
        - Equip health care industry to advance equitable innovation
    - *In Full Health* is the initiative to provides framework for shared understanding and a community for stakeholders that are committed to learning and action to center equity within their health innovation investment, development, and purchasing
        - Broader framework to help people get on the same page and learn from each other and make decisive actions
    - The *In Full Health* community focuses on:
        - The business case, and developing core principles for business.
            - It's actually very good for business to focus on these issues
        - Putting together resources and tools to help community members bring core principles into their organizations
    - Despite increasing investment in health innovation, the U.S. has worse health than other high-income nations, and has persistent inequity
    - Exclusion of the majority of the U.S. population from health innovation resourcing is preventing meaningful progress in national health improvement
        - Women and other marginalized groups are minimally represented in financing and development in this area
        - There are well-documented financial performance benefits of inclusive and equitable decision-making and resource allocation
        - Measurable progress in national health and economic prosperity will be made by investing in solutions that include Black, Indigenous, People of Color, women, LGBTQ+ people, people with disability, low income people, and those living at the intersection of historically marginalized communities
    - The Principles
        - Dismantling structural racism, sexism, and bias in health innovation resource allocation begins with the organizational self-assessment
        - Impact of health equity is a fundamental metric that should be used in assessing the value created by all health innovations
            - No quality healthcare if there is inequality in healthcare
        - Greater investment is needed in health innovations developed specifically to improve health in and/or eliminate inequities experienced by historically marginalized communities, with resources and support prioritized for innovators designing from within these communities
            - Cannot just "include" these communities, must be designed specifically FOR those communities
            - Need to include developers FROM those communities
        - More health innovation models should support asset ownership and wealth development within historically marginalized communities
        - While health innovation funders, solution developers, and customers have a significant opportunity for impact at the organizational level, we need industry influencers to engage in addressing systems-level barriers and needs
    - Information about content and tools including resources, as well as events and support, are at InFullHealth.org

Questions

- KP Yelpaala: Is this presentation available to the groups?
    - Dr. Gibbons - already sent out to all
- Jody Ryan: We have been asking our EHR provider to consider embedding decision support tools within the EHR points of care where provider bias and inequity are predicted to occur. These tools could be placed in field-recognized places where field-known equities occur in

specific places where our practice has discovered impractice inequality patterns. This can alert the provider and help providers become more aware of their unconscious biases and assumptions and their impact on care and alter outcomes. We also need better outcome data.
    - Dr Gibbons: I agree with that. This is complicated, and there are opportunities and challenges at many levels, and getting these things in place at the EHR level is a challenge. Already there is work being done at this level using, for example, AI. There is promise there, but it isn't totally ready.
- KP Yelpaala - This touches an intersectionality between DEI and health equity. Can you speak to the link there and frame the DEI issue?
    - Dr. Gibbons: One area that we have really missed the mark is that we have not been as precise as we need to be. Not just anything that focuses on marginalized communities is a DEI project or an equity project. There are gaps not due to patient choice, but to other factors that are built into the system that constrain or are above patient choice. There is absolutely no scientific evidence to show why any one population should be healthier than another. Not just any intervention is an equity project, or effective. An equity intervention closes a specific gap, not just raise the overall health of a population.
- Toni Baruti - Thank you. This is so needed, I have seen this so much and it falls on deaf ears. It is so important to check your biases when you do health analytics, making sure you're making the right assumptions, and understanding the importance that culturally responsive care is provided.
- Art Davidson - If we take the objective, "Embed equity within evolving AMA innovation efforts" and substitute "AMA" with "Colorado", do all colleagues agree with this model? Is this worthwhile considering in our commission purpose of encouraging innovation? And what are the things we can do with these four objectives?
    - Dr. Gibbons: We at the AMA think that this should not be a proprietary tool, but is being disseminated under a Creative Commons license, so you can take it and use it and adapt it so we can share a common framework.
    - Art Davidson: How do we move money to historically absent groups? How can we encourage that in Colorado? If we could agree to this in principle, we can make steps towards that.
    - Dr. Gibbons: This part alone is complicated, but start by talking to the people in your group. There are multiple ways this can be done, and the way the AMA does it may or may not be appropriate for Colorado at all. Historically, some populations have not been at the table. Now we are thinking about changing that, but even as we do so, it's like given a person who has never ridden a bike because they couldn't afford one a new bicycle and asking them to enter a race. Their ability to do that will not be there. This isn't perpetuating a problem, but this is difficult work. Find out what's best for your communities and build trust and stick together.
- Wes Williams: What might be powerful is to take that model and come up with specific examples of what each of the four elements might look like here in Colorado. Just get concrete examples and ideas so people can understand what it would really look like. This really comes back to putting money places to make change.
    - Dr. Gibbons: Those who control the money are not generally going to be in favor all of the time of changing what they're doing.
- KP Yelpaala: Let's talk a little bit about rural populations because that matters a lot in our context and how we framed our health equity issue in the refreshed IT Roadmap to ensure we are thinking about both rural and urban contexts. What have the conversations been around that?
    - Dr. Gibbons: At least at a high level, these principles can apply no matter the urban or rural context. I am aware that some things are much more challenging in the rural environment or city environment, but this is another example where it is important to talk to people and start that conversation.
        - North Dakota example: Most of the whole state is rural, and their vision was to make tech available statewide and be the first "smart" state. Don't think it is impossible just because there are rural considerations or difficulties, and there

are people out there working on these things. Reaching out and speaking to these people will help in figuring out how we do this in Colorado.

- KP Yelpaala: In terms of applying this framework in Colorado, the refreshed IT Roadmap has embedded equity principles, and the AMA leadership gives us a framework to vet our directionality in how we frame health equity and digital inclusion. We also have two workgroups, the Care Coordination workgroup and our rural workgroup, so maybe one of the tasks here is for the OeHI team to look through these principles and apply that thinking into our workgroup sessions and vet what we're planning. We are trying to operationalize the Roadmap. Stephanie, what are you thinking?
    - Stephanie Pugliese: Going into communities and speaking directly to people about what has worked and what hasn't is an important part. Also, joining as a collaborator with In Full Health. All of us are action-oriented and can work to tailor it to Colorado, but we don't need to reinvent the wheel and can learn from experts around the country.
    - Dr. Gibbons: We have a draft of a self-assessment that we are going to start making public to finalize it.
- Jeffrey Nathanson: This sounds like an impressive group of partners. Has the AMA been able to bring their social justice views to the private investment and DC community, powering the development of digital health products?
    - Dr. Gibbons: None of this will happen overnight, but that is the direction that this work is going. As a starting point, we are working with those who buy and develop. We had weeks of debate on where we start, but this isn't where we're going to stay. But hopefully this will help start us in that exact direction.
- KP Yelpaala: I really appreciate the context given to all of this and the nuance you [Dr. Gibbons] have unpacked for us.

Workgroup Updates

Stephanie Pugliese

- Stephanie Pugliese: Following up from the last meeting, I wanted to share our tweaked and updated principles. Last time we talked about some proposed principles that were overall supported, making sure we collaborated and built on previous workgroup work.

Gabby Elzinga - Rural Health IT:

- The Rural Health IT Steering Committee has met twice as a refreshed group. We are working to update our partnerships. Last meeting we talked through Contexture's rural IT strategy. They have 13 CAH and 17 RHCs left to integrate into the HIE landscape. The goal is to connect all of those folks by June 30th, 2024.
- We have also been talking through OeHI's additional rural connectivity funding which was approved by the Joint Technology Committee and includes $11mil in one-time matched funding. That's a broadly defined bucket of funding meant to expand rural connectivity out to independent providers. This can include primary care, behavioral health, and social care in rural communities.
    - The next step is to develop a funding strategy for this pot of money.
- Our next meeting is coming up on May 17th.

Toni Baruti - Care Coordination Workgroup

- We have gotten our workgroup together, and it was hard because we wanted to keep the workgroup small, limited to 12 folks, but diverse across all areas. We have a good group of different backgrounds, sexes, religions, sectors. We have groups from primary care, behavioral health, and others. Everyone is welcome to attend the public meetings.
- Our goals are to understand what is currently happening, what has happened before, what we plan to happen, what work has been done in the community prior, and go from there.
- We are using previous workgroup work as our starting point. A lot of really good work was done, and we want to utilize that to catapult us forward. Invitations have been sent out to the group of 12 and we will start our meetings in June. More to come in our next eCommission

meeting.

Public Comment Period

- Rachel Dixon: I just wanted to say it was so exciting to see Dr. Gibbons and learn more about In Full Health. As a general announcement, we are recruiting health tech companies, startups, and founders for this year's challenge in California and Colorado. There is an emphasis on underrepresented founders. If you have any ideas or know any founders, please send them our way. The OeHI Summit is coming up in July and we would love any ideas for speakers.
    - KP Yelpaala: Prime Health is now part of the In Full Health system.
- David Aylward: Having spent time focused on care coordination personally and with diverse colleagues, I just wanted to flag a real concern we're getting. While every one of our programs focuses on social determinants or behavioral health, we seem to be heading for saying we need our own care coordination program. OeHI seems to be the only org able to push against the need for creating new care coordination programs when we already have multiple in the state and to really look at patient-focused interoperable systems. A strong word of encouragement.
    - Toni Baruti: I appreciate what you said and it's so true. It's so important we look at everything holistically and what we are currently doing and making sure there is not duplicative work or a burden of administrative work. I understand what you mean by operating by programs. Understanding how to make sure that is all integrated with care coordination and making sure you are providing equitable care goes hand in hand, and making sure it is interoperable and implementing something that makes sense and isn't just additional administrative burden. I encourage you [Alyward] to join the Care Coordination meeting as an attendee.
    - Stephanie Pugliese: I am speaking with the other care coordination workgroup in preparation for the refreshed workgroup to make sure we aren't reinventing the wheel or working in silos, and I echo the invitation to join the public workgroup. I am happy to send out the invitation to the newsletter.
- Toni Baruti: The hope with this group is that we can simplify things. We are going to start with the work that has already been done, but everybody already has their own system and repositories of data. If we could make everything interoperable and people-centered, with access to all the data that surrounds an individual, that is the work we are trying to do. Bring your ideas please!
- Stephanie Pugliese: The vision for the SHIE -name pending- is to be a vendor-agnostic system. I don't foresee that it is possible to build a single system, but we need to connect the systems so they work together.
- Jackie Sievers: Is there a membership from the social sector in the Care Coordination Workgroup?
    - Toni Baruti: Stephanie, do you have the list of members and their organizations?
        - Stephanie Pugliese: Yes, I'll find it and send it.

Action Items

KP Yelpaala

- KP Yelpaala: One thing is that we can have our workgroups take a look at Dr. Gibbons' presentation and determine how we can leverage some of that work and how it fits into their work. It is a conversation we can continue.
- In terms of agendas, with the workgroups, today was a shorter period of time for updates, but we are going to start integrating more time into the agenda to dig into the workgroup work and unpack priorities. Expect that in future agendas.

eHealth Commission Meeting Closing Remarks

- Open Discussion

Motion to Adjourn

Kaakpema "KP" Yelpaala, *eHe**alth Commission Chair***

- Kaakpema “KP” Yelpaala requests motion to adjourn
- Jackie Sievers motions to adjourn the meeting
- Amy Bhikha seconds the motion
- Meeting adjourned at 01:59 PM MST