Meeting Minutes

7/10/2024| 12pm| Virtual Meeting Only

Type of Meeting	July eHealth Commission Meeting
Facilitator	KP Yelpaala, *eHealth Commission Chair*
Commission Attendees	KP Yelpaala, Cory Hussain, Kevin Stansbury, Krystal Morwood, Micah Jones, Parrish Steinbrecher, Toni Baruti, Jackie Sievers, Amy Bhikha, Mona Baset Absent: Michael Archuleta, Rachel Dixon, Sophia Gin, Patrick Gordon, Michael Feldmiller, Misgana Tesfaye

Minutes

Call to Order

KP Yelpaala

- Quorum Met: No
- Voting of Meeting Minutes: N/A. Quorum not met
- Confirmed with Commission that July meeting was motioned to adjourn by Katherine Hochevar (delegate for Amy Bhikha) and seconded by Michael Archuleta.

Announcements

KP Yelpaala

- Today we will cover a Rural Connectivity update, review progress on the Health IT Roadmap Refresh, and an update on the Digital Health initiative. But first, I'd love to turn it over to our Lieutenant Governor for opening remarks. So over to you, Lt. Governor

Lieutenant Governor Dianne Primavera

- I am proud of the work that OeHI has accomplished in the past year, and excited to see where this next year takes us.
- I have enjoyed joining the OeHI team on a few of their Roadmap road trips, and talking with providers and community members about the great work happening all around the state. These conversations have reinforced that truly, ALL roads lead to health.
- One of the things I most enjoy about my staff is that they are always dreaming of creative and innovative ways to support Coloradoans and improve how we do our work. I would like to extend that inspiration to you, our eHealth Commission, to truly think boldly and beyond the bounds of how we have always done things.
- So the work presented today demonstrates the broad spectrum of efforts in health innovation, and that we always go further together. So with that I'll turn it back over to Stephanie Pugliese, OeHI's director.

Stephanie Pugliese

- August eHealth Commission Meeting will be hybrid. Please join in person for lunch, if you can.
- We are hiring for an Operations and Special Projects Coordinator and a Technical Project Coordinator as well. That first position closes the 17th, so a week from today. And then the Technical Project Coordinator position closes today.
- Is the Commission interested in drafting a comment to the Health Data, Technology, and Interoperability: Patient Engagement, Information Sharing, and Public Health Interoperability (HTI-2) Proposed Rule?

New Business

Rural Connectivity Update

John Kennedy, OeHI, Rural Connectivity Lead

- In partnership with Health Care Policy and Financing (HCPF), we received approval from the legislature for an annual sustainability payment to our Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs), called the R7 sustainability payment.
    - CAHs will receive $100,000 and RHCs will receive $20,000 annually for participating in the Rural Connectivity Program.
    - The first payment was sent out March 1. Following that payment, we identified an accounting software default where if there is any sort of money owed to the State, any payments that are released will have that deducted.
    - Having learned this, we are prepared for the August 1st payment. We have set a maximum recoup amount for each of these qualified facilities for one cent.
    - So now the funding will be released as intended- to help them keep their doors open and make lives better for rural Coloradans.
- We are also preparing for our next phase of the project. We are currently working with our Capital Construction budget, called CC02. We will be submitting a request to extend this funding an additional 3 years to ensure we can appropriately spend this money, since we received a higher federal match rate than initially anticipated.
- We have been focused on making the Community Analytics Platform (CAP) valuable and utilized by the rural providers. In the last quarter, thanks to the hard work of all of our partners in this space, CCMCN, Contexture, QHN, and CRHC, we've seen a 23% increase in usage.
    - And then a 28% increase in the organizations that are using it. So thank you to our partners and the providers for participating in this program.
- For our next focus areas, we have some big priorities to cover.
    - Consistent feedback that I've gotten from rural providers is that a burden to them is having to report the same information multiple times to different state agencies. It's a burden on resources. It's a burden on technology.
        - One of the things that we're looking at doing is creating a centralized reporting entity. This would have all of the information that they need to report is already in our CAP. So if we could set up this information to be reported on their behalf, that would be a big win.
        - To start, we are going to do what I'm calling an environmental scan. We will clarify everything that's being reported, and to who. There could be several factors in this. Maybe providers are reporting something they don't need to. Maybe the HIEs are already reporting it, and the provider just doesn't know that they don't need to. We just need to know what all is happening from providers and from the HIEs.
        - So our Steering Committee has put together some ideas and some thoughts and some concerns or anything that they could think of for this topic, and I wanted to put those here and showcase those to the Commission.

Kevin Stansbury: We're starting to emphasize this through the Eastern Plains Hospital Consortium (EPHC) and the Colorado Hospital Association (CHA). I learned a couple of weeks ago that only about 50% of the rural hospitals are submitting data to the CHA Data Bank, which is really leaving our data with a big hole in it. And so I would encourage you, John, to work with CHA about finding ways, because that data bank is a very rich deposit of data that we use in my hospital a lot, and it'd be nice if we had the data from all of the hospitals.

John Kennedy

- I think we're on the same page, because I've already reached out to CHA. I think it's all part of the same ecosystem. And really, when we go out and do this environmental scan, this will be a part of that. Who needs this data, and isn’t getting it? Why aren't they getting the data right? I think we have to have this baseline to be able to really understand, because there's just so much back and forth.
- So the next bullet here is the second phase of rural providers, identifying those outliers and how we can get them to be a part of the program

- When we started the program, and identifying who would be allowed to participate in the CAP, we based the criteria on the Federal designations. So this includes Critical Access Hospitals and Rural Health Centers, according to Centers for Medicare and Medicaid (CMS).
- As the program has continued, there are a few facilities that I'm affectionately calling the outliers.They're the hospitals that maybe are Prospective Payment System (PPS), or maybe they joined together in order to survive. But now on paper they have more than 15 beds. There's a bunch of different, interesting, unique things that have happened in rural Colorado. Unfortunately, that's excluded some of the providers that service rural Coloradans from our program. So we're going to see what we could do to bring those into the fold

Kevin Stansbury: Just a note on that for everybody to understand. 25 beds is the Critical Access Hospital (CAH) designation, and there are some CAHs in the state that are doing very well financially. On the flip side there are some larger PPS hospitals in the state that are struggling. So I really appreciate John's willingness to re-look at that, and help out some of those hospitals that need it that don't have that CAH designation, but really need the support from a financial standpoint.

John Kennedy:

- Absolutely, and then this will evolve to look at other provider types in rural Colorado that need help. You can see some categories here like hospice, free clinics, etc.
- The next priority is enhanced and upgraded network security. This is a priority for our rural facilities, to protect against ransomware and attacks.
    - So the goal here is to figure out how to get dollars to our rural providers to enhance their cybersecurity and their network security. It's going to be through education and assistance. So, for example, USAC funding is readily available for this type of work. It works very well. It's a matter of education and understanding how to navigate that system.
    - And so how could we do that? How can we help our rural health facilities tap into this funding stream to upgrade and make sure that they're protecting themselves?
- The next priority, which is a huge one, is EHR/EMR sustainability. The costs for implementing and maintaining an EHR/EMR are out of reach for many rural providers.
    - In considering options of how we can help, I have been looking into the OCHIN model. If you're not familiar with OCHIN, it is a nonprofit based out of Oregon. They're essentially a help desk for the EPIC EHR.

Cory Hussain: OCHIN uses an instance of EPIC that is a lot more affordable. It is a huge network of federally qualified healthcare centers across the country that provide care to a very marginalized population, and do it in a very cost-effective way, and would be a great model for your rural healthcare systems to copy that. You're absolutely right- EHRs are not a one-time cost. You have the upfront costs of purchasing the module that would work right for your organization. But then there is an analytics cost associated with that in order to build it that is pertaining to your own organization. And then the maintenance costs.

- How OCHIN was able to do that was to share that cost between these multiple small clinics that contributed a small amount of money as part of their revenue cycle. So they weren't straddled with owning a massive EHR. They all came together to own one instance. The only issue around that would be a BAA, a business use or a data use agreement between these organizations, to make sure that they're able to share that data within a single instance. Because when we think of organizations we think of each entity owning an EHR, and owning that data that lives within that EHR.

Kevin Stansbury: So, Corey, thanks for your comments on the OCHIN. And again, kudos to John, and others for exploring that. I, as John knows, I have some reservations on the OCHIN model. And it's more just out of ignorance about it. I want to learn some more about it. And John knows this, but Oracle Health has developed a product that's appropriate for Critical Access Hospital size and availability. And it's kind of on a similar sharing platform. So I just want to make sure that we don't get laser focused on a single solution because there are other options out there.

- Right now on the Eastern Plains, 7 of us are either on Oracle Health right now, or migrating to Oracle Health. So there's a growing group of hospitals in the State, and there's at least 3 other rural hospitals in the State that I know of that are on the old Cerner system, but still the Oracle Health system. So we have an opportunity and a couple of different areas to address this problem.
- But again, I want to emphasize this issue of the ongoing costs, and really effectively using the system for data, extraction, and management of our patients. The more we can help out the rural facilities with that, the better we will be.

Cory Hussain: So, Kevin, it'll be the same challenge, even with Oracle Health, right? I totally agree with you- we don't have to get fixated on which EHR or solution it is. The problem will happen in terms of who owns the instance of the EHR. There has to be a contractual obligation, and what the model needs to be is, how do we distribute the pain points and the costs to these rural entities to come together as one entity and use one instance.

Kevin Stansbury: That's right, and EPIC has a pretty high cost point. That's why Oracle was a little bit attractive because they didn't. They've been able to bring that down, and it's a shared model as well. I know that our friend Dave Ressler in Aspen has the only rural hospital I'm aware of that operates on EPIC, and he has talked about how maybe there's some sharing opportunities we have.

- And of course, UC Health and Common Spirit are looking at other ways that they can share that model as well. The problem again comes back to what you said, Cory. It's the data ownership and access to the data. And there's still a very high cost of entry when you buy one of those shared systems from a bigger system.

John Kennedy: So there are a few components here. First, there's the EHR. Then you have to have the help desk that sits on top of that, and that's essentially what OCHIN is. So if we're looking at this model, we're going to have to create an entity that can provide technical assistance for ongoing support.

- So OCHIN comes in and they provide that help desk and that assistance, and that's why they're so sought after. So I've been working with EPIC to understand what it would look like if the State of Colorado was to adopt this format. And again, it won't necessarily be EPIC- that is just the example. But the more that buy in and the more facilities that buy into this instance, the lower it reduces their cost.
- So that is something that's appealing. The other thing that has to be considered is if there is a lead hospital or facility owning the instance. They could prioritize their needs over the rest of the participants. So we're really looking at this more holistically. We're all in this together. This is us buying into something. And to Kevin's point it won't necessarily be epic. But the top two are really Oracle Health (Cerner) or EPIC.

Kevin Stansbury: I just wanted to respond to Tom's comment about the server cost in the chat. Tom, that's a great point. And actually, again, one of the areas where it's gotten much more affordable because the EPIC system, as John describes it, and certainly Oracle, they're all cloud based systems right now. So we have very little investment in Cerner and local servers, and we're seeing a lot of improvement in that interface. So you're exactly right, Tom, that goes a long way to reduce that cost.

John Kennedy: Yeah, it's a huge thing. It's going to take at least 4 years. I'm also working on understanding how we can get Centers for Medicare and Medicaid Services (CMS) match for the funds. The State of Hawaii was able to get a 75% match for these costs. Originally, we thought CMS would not help because they had already paid once, which is a part of a larger conversation. Part of this is also bringing awareness to leadership. The Lieutenant Governor goes with me on some of these trips, and I'm always making sure she hears how expensive this is, and I think everyone here knows, it would blow your mind how expensive this is to not receive any assistance or help.

- The other thing is that we're going to be digging into this next phase is how we can further assist the rural communities. So we're putting money into these Critical Access Hospitals and these Rural Health Centers, but how can we make sure that these dollars are also impacting other parts of the community.

 - Part of the way that we're doing that is asking questions like, How are you doing referrals? Do you have a food bank in your area? How do you refer someone who has food insecurities to that food bank and just working through understanding that and how we can get those dollars out there. These critical access hospitals tend to be the hubs for a lot of people. They employ a lot of people in the community for various jobs, and a lot of people turn to these leaders in the community- we have some on the call, like Kevin Stansberry, who are leaders in their community that are making sure that things are working. So we want to make sure that as we give out these funding and these assistance that we know that we're continuing to and even really getting into the community and helping out.

Kevin Stansbury: I just want to commend you and Stephanie and the rest of the OeHI team for their good work. And Lieutenant Governor Primavera.

- Just a quick pitch, if I may. I met with Emily King last week in the Governor's Office. There's a statewide group called Rural Futures. And we're looking at challenges like the EHR challenges and other operational challenges. And we'd very much like to get a platform as we prepare our policy roadmap on other ways that we can work with the State.
- I love what Cory shared with Ohio state in the chat. But we're looking for comprehensive ways that we can lift all boats. And John, you're exactly right. The work that we do in rural is very much the same situation as Denver Health. We're the safety net hospital for our part of the State. We have a much smaller population, but we're faced with many of the same challenges. So we look forward to providing that rural policy roadmap to this group as well as to other policy makers in the State. And again, Lieutenant Governor Primavera, I thank you for letting me meet with Emily King last week to talk further about this.

John Kennedy: Yes, thank you so much, Kevin. And then Cory, please share your Ohio information as well. I do reach out to my counterparts and other states, just to see what their successes and lessons learned have been. Also, everyone is so supportive in our group. The HIEs, Colorado Rural Health Center (CRHC), Colorado Community Managed Care Network (CCMCN), and I know they're on the call. So I want to make sure that they know how thankful we are for their work. If there's no other questions, that's all I have today.

Kaakpema "KP" Yelpaala: Good work, and thanks, John. This has been a wonderful conversation. And Kevin to your point, yes, this is a really important issue. So I have no doubt that Stephanie and I and others on the Commission want to support this. I think you guys have made a lot of great progress which we're hearing about. But you know, there is definitely a need for a combination of policy work, and this type of coalition.

- You're basically talking about the right to engage the vendors and to exert some influence because it is absurd. I might even use the word disgusting about how expensive this is. So thank you, everybody. This has been great.
- Also, it's a great segue to the next part of our conversation, because Stephanie and Ashley will be talking about our Health IT Roadmap refresh, and our digital health equity work. So as far as I'm concerned, this also should be in our minds, as we're thinking about this next Health IT Roadmap, and how these rural needs fit in with the part of our digital health equity game plan going forward. So with that over to you, Ashley and Stephanie.

Health IT Roadmap Refresh Update

Stephanie Pugliese: Thanks. KP, and thank you all for wonderful engagement throughout that rural presentation. And of course, John, thank you for all of your work. So we just wanted to give the Commission an update on our Health IT Roadmap refresh efforts.

- We are still within our estimated timeline. We started conducting listening sessions back in April, and we are still driving around the State and meeting with providers and community based organizations and libraries.
- We've been really lucky to have welcoming friends in all parts of the State. So it's been really rejuvenating for our team to to really get out and talk with the folks that we care the most about, and make sure that our work really is impacting those that we're aiming to help. So we

are on track to have those listening sessions wrapped up by August or September. So likely further in September, just because summer is a challenging time to schedule things.
- So then we'll move into drafting the actual roadmap language in October through around December.
- We've intentionally built in a lot of buffer time here, too. Just from experience, we know things don't always go exactly to plan.
- So we may even get done earlier than anticipated. So then we'll work to circulate that draft language for public comment. Of course, we'll start with the Commission, for your feedback, and then release it to the public for their input as well.
- We are aiming to have the updated Health IT Roadmap published by March of next year. With that, I will pass it to Ashley.

Ashley Heathfield: Thank you. So I want to share a little bit about what we've done so far, and where we've been. So we have the OeHI team that's going out and conducting site visits in person. And this map shows where OeHI has been and is in this dark green color. Looking back, I could have used different colors, so apologies for that. But dark green is where OeHI has been.
- And then we also funded community-based organizations across the State to host listening sessions within their communities, whether within their organizations or with community members, which are in the blue/green color. And then there's a lot of overlap between those two, and then the blue is where OeHI is confirmed to go.
- But this is where we've been and where we've heard from so far, or where we're going to go. We have more trips planned, but we don't have the sites confirmed yet. So there is an ask later on in the slides to provide your contacts, if you know folks in different parts of the State.
- So far we visited 22 different organizations, including hospitals, behavioral health providers, health clinics and libraries.
- Through these trips, we have spent about $6,000 in local communities thus far, and have engaged 32 healthcare staff through these visits.
- From the listening sessions that we funded, there were also 22 community-based organizations that participated. $126,000 went to those organizations to host those sessions, in 8 languages throughout all of the different listening sessions.
- Overall, we've had 332 people reached through that process. So then you can see a bulk of those as community members, and then 88 healthcare staff and 46 communities organization staff.
- Organizations also provided incentives to participants, particularly the community member listening sessions such as gift cards, meals, childcare. These organizations work with their community members really closely and so they know the meaningful incentives that would bring folks to the table. So it was really exciting to be able to do that.
- So what we're hearing so far from the OeHI trips, and John touched on several of these already, but Federal and State reporting requirements are a huge burden. The costs of technology and keeping existing technology up to date and running is also one. And then we're hearing quite a bit about Medicare advantage and reimbursement from commercial payers as being a barrier.
- Our next steps are starting to analyze the data that we have. There are quite a bit. So we're in the process of developing a process for going through that, coming up with themes and then having that feed into the Health IT Roadmap and inform our priorities, and next steps. And then, as Stephanie said, we'll continue conducting OeHI site visits across the state for the next couple of months.
- So here are the 3 regions that our team is going to, that we would still love to have more contacts. So if you know organizations in these areas or counties, that would be great. Any questions here?

Cory Hussain: When they are talking about the Federal and State reporting requirements being a huge burden. Is it an amorphous burden? Or are they looking at specific things like, for Federally Qualified Health Centers (FQHCs), they have significant reporting burdens. Is that what you’re seeing?

Ashley Heathfield

- We're going to have to tease it out a little bit more. Right now, thinking about our trips, we haven't pulled apart the specific burdens for specific types of facilities. I'd say most of the organizations we visited, regardless of their type of facility, have been in more rural areas so far.
- So I think it comes back to kind of what John was saying. A lot of the reporting is to the state. There's an acknowledgement that we might not be able to do anything about Federal reporting. So a lot of the focus has been on state reporting, and it's just the different agencies that they have to report to.
- Some of our sister agencies have come up, and some of the programs across the agencies that folks are engaged in, as being redundant but also slightly different requirements. And so that makes things really challenging as well.

Kevin Stansbury: If I might follow up a bit from my experience, and what I observe with my colleagues out here in the rural areas. It is a lot of state reporting, as you noted, and one agency might ask for the data in this format. Another agency might ask for the same data, but in a different format.

- And I have to give HCPF credit. If there's anybody from HCPF on, I will note that it's unusual for me to praise HCPF. But they've done a really good job of listening to that and trying to streamline the reporting, particularly under the Hospital Transformation Program (HTP). So that's what we're looking for, is more understanding that it is burdensome for a hospital to report the same data in different formats to different agencies. It'd be great if we had a single clearinghouse for the data.

Digital Health Initiative Update and Discussion

Ashley Heathfield: I will move into an update on a project that we are kind of in the midst of in Northwest and Western Colorado. Just a couple of months ago, we finished up a phone survey of 800 adults in Northwest and Western Colorado to look at how Coloradans in this part of the State are using telehealth- how many people are or aren't self-reporting their telehealth use? What are the barriers to using those services, and particularly for those that aren't using telehealth? And then what benefits and concerns would be most effective or convincing in terms of using those services?

- And the reason that we focus on this part of the State is, as you can see from this map from CIVHC, this part of the State sees lower telehealth utilization.
- From a broadband infrastructure perspective, according to the Broadband Office's map, these are not areas that have very low infrastructure.
- Current and statewide data doesn't allow for drilling down to kind of uncover what's happening at a local level- if there are perceptions or local barriers that folks are experiencing that are keeping them from being able to take advantage of telehealth, or if there's a level of awareness.
- The goal was to gather local data to then drive local change. So if it's a perception or concern about quality, maybe there's something we can do with public service announcements or working with local providers to drive some communication out to the community to address those concerns.
- So about 70% of respondents did report using telehealth. And you can see the graph on the left shows the types of providers that they're engaging with.
- It was surprising that dental care came up much higher than mental health care. So something that we're interested in digging into and then overall, regardless of if they use telehealth or not, almost 30% of folks were unaware whether their provider offers an online portal that they can access.
- It seems that there is opportunity to build awareness around that but again, those that are using telehealth.
- Then this graph down to the right shows how folks are engaging with providers. So telephone calls are the most common.
- Again, a little surprising that video calls are so much lower, where email and text messaging are coming up higher than that for folks that have used telehealth.
- The top benefits were that the providers seemed comfortable using telehealth, and that it

saved them time.

- But then, interestingly, folks 70 and older, and those making less than $25,000 a year were least likely to agree with any of these benefits.
- About 30% did not use telehealth services. However, 21% said that their provider doesn't offer them, but they would be willing to use them if they were offered.
- If you look at that little pie chart in the lower right hand corner, there are about 30% that say 'My provider doesn't offer telehealth services, but even if they did, I wouldn't use them.'
- About 44% say, 'They offer telehealth services, but I don't want to use them.'
- About 18% of folks that are not telehealth users are Internet insecure, and we did not dig into why they are- it could be lack of consistent access, too high of costs, or other things.

Kaakpema "KP" Yelpaala: Sorry to interrupt. Quick question- did you look at mobile phone Internet connectivity in this?

Ashley Heathfield: We did. We looked at cell phone usage or ownership. And also mobile data and seeing if folks were running out their data. We didn't pull that into the telehealth usage for this slide. But I do have that. And we can continue to refine that because it is really interesting. If you're running out of data, or if you have a cell phone only, you're probably not a big telehealth user.

Kaakpema "KP" Yelpaala: Yeah, for a lot of low income households, they get their Internet through their phone. Thank you, Ashley.

Ashley Heathfield: And then the table to the left hand side shows the benefits that would impact them or drive them to use telehealth. So, being able to schedule a same day visit to see your regular doctor, and then avoiding commutes for safety. And then it kind of goes down from there.

- So our next steps are to use this information to inform a public awareness campaign in this part of the state. We want to work with local providers to leverage trusted voices in the community and communicate what telehealth is, and why it's just a tool as part of your healthcare.
- Privacy of information was a top concern for both telehealth users and non-telehealth users. So using data like this to drive the most effective messaging.
- As part of this work, Connected Nation also created a communications recommendation plan, with an estimated budget of about $70,000. And that includes social media. Again, creating PSAs and videos. So that's what we're thinking for the next fiscal year.
- From the Commission, I would welcome reactions to this approach, or any reactions to the data, what the next steps are, or about doing additional data collection in other parts of the state.

Kaakpema "KP" Yelpaala: Well, this is great, Ashley. Can you remind me, what are you thinking about next year with this data, in terms of any other insights you want to dig into, or how you want to get this out there?

Ashley Heathfield: I think really speaking to some of the concerns and particularly focusing on non telehealth users. Also focusing on the demographics of those folks, and their biggest concerns and biggest drivers for wanting to use telehealth.

- Creating messaging around what these services are, and speaking to those concerns as well as what the benefits are, and seeing if that changes any of the adoption of telehealth in this part of the state.
- We want to see if that drives larger changes in those populations. Particularly older adults shouldn't be left behind in benefiting from telehealth, and working to show how this fits into their overall care plan.
- We also want to communicate that patient portals are a resource, and help ensure that everyone is able to benefit. Making more of a level playing field for what all of this means- sometimes we take for granted that everyone is really familiar with what telehealth is and how it's used.
- But I think in terms of next steps, also looking at some other parts of the state that have

lower telehealth utilization, like the far Eastern plains, or maybe parts of the San Luis Valley. Alamosa actually has pretty high telehealth utilization for a rural county. Kevin, I'm interested in your perspective, too, from your community, as we kind of have gone around the state. Different areas are really adopting this or not from the provider perspective.

Kevin Stansbury,: Yeah, Ashley, thanks. It is a really important initiative. And I appreciate you gathering the data. One thing I would point out, I think the assumption often is that there are generational divides on the willingness to use telemedicine. What we're finding is that is not the case at all. We've had patients who have a primary care visit, and they'll literally get all dolled up because they're going to be on TV with their doctor.

- Then we have other people who are much younger, who just want to check out and don't trust the technology. So I would caution everybody not to make the assumption that this is a generational thing.
- And then the other piece, I say this every time I get a chance to talk about telemedicine, is that telemedicine is a wonderful supplement to primary care. It does not replace primary care in person. I would continue to encourage our providers and others to make sure you maintain that in-person relationship that can be supplemented by primary care.

Ashley Heathfield: I really appreciate you bringing both of those points up, Kevin. I think this is also an effort at supporting patients and being comfortable to ask for these services when they need them.

- There is implicit bias that plays into everything that we do, and so, making sure that if a patient isn't offered a service because there's some assumptions made about their ability or willingness or interest in using it, this is a way of giving folks the self-advocacy tools to be able to say, 'Oh, yeah, I understand what this is. And I would like to use this, even if it hasn't been offered to me yet.'
- And we really want to focus on those local providers and help to make sure that their services are out there, versus necessarily connecting to outside external organizations. So thanks for bringing that up, Kevin.

Jackie Sievers: Thanks, Ashley, and thanks for all this information. I wanted to touch on what you just brought up, about where the provider is located. I know we hear about that, and especially when I worked in the Delta/Montrose area, people didn't want to connect with a provider that was outside of their geographic region. I didn't know if you captured here, when folks used the telehealth provider, was it somebody that was based in their community or not?

Ashley Heathfield: No, we did not ask about that. I think that's a great point. We didn't ask about what type of provider, or if it was a provider they normally use. We can see the type of provider that folks were connecting with, so specialty care was up there, and primary care was really big. So maybe that's something we could further dig into- are folks using telehealth with their local primary care provider?

Kaakpema "KP" Yelpaala: Great. Thank you so much. That was a really good summary and great progress. Stephanie, I actually have one thing for you before we jump. Regarding the Health IT Roadmap Refresh, what ask do you have of our Commissioners, of how they can support the process?

Stephanie Pugliese: I appreciate that, KP. Our main ask is that we have a couple of areas that we are struggling a little bit to get contacts in. Thank you to Kevin for helping us gain some contacts in the Eastern Plains.

- I think that's where having this group vouch for OeHI, and that we are legitimate and also are coming out to help, and helping explain that what we're doing is valuable. So when I send the follow up email with the proposed rule, I'll remind the commission of those areas in case you have any contacts.
- Otherwise, I think the ask is just to be prepared to provide some feedback this fall as we draft the strategy. Right now, we're really just in the information gathering phase. But I think the ask right now is to be ready to react.

Kaakpema “KP” Yelpaala: Great, wonderful. Thank you so much, Stephanie. Really great discussion and engagement today. So we appreciate everyone really engaging with this subject matter and content today.

Public Comment Period

Carolyn Ridderman: With regard to the Roadmap refresh, do you have a sense of any new directions or big issues, or will the refresh focus on fine-tuning or continuing ongoing initiatives?

Stephanie Pugliese: That is a fantastic question, and I think it's a little bit of both. I don't think we plan to do a 180 degree pivot and change all of our work, but we also want to use this time to really fine-tune what we're doing and understand what might be on the horizon.

- As everyone on the Commission and attending this meeting knows, technology moves quickly. Especially these days, a lot of burgeoning areas like AI, and cybersecurity and other areas that we may not have seen in the 2021 version, we want to make sure that we're staying current on those.
- I think another goal that our team has with the roadmap refresh is to have a bit more granularity in this next version to really explain our work at a more personal level. With each roadmap, we've seen it get more granular, specific, and hopefully more understandable. We aim to do that with this next one as well.

Action Items

- *Next meeting: August 14, 2024 and will be hybrid*

Motion to Adjourn

KP Yelpaala

- KP Yelpaala requests motion to adjourn
- Kevin Stansbury motions to adjourn
- Amy Bhikha seconds the motion

Meeting adjourned at 1:11 PM