OeHI
Office of eHealth Innovation

eHealth Commission

Meeting Minutes

5/8/2024| 12pm| Virtual Meeting Only

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

Minutes

Call to Order

KP Yelpaala

- Quorum Met: Yes
- Voting of Meeting Minutes: Yes
- Corrections for April 2024 eHealth Commission meeting minutes
- Corrections: None
- In favor of approving: Misgana Tesfaye and Michael Archuleta
- Opposed: None

Announcements

KP Yelpaala

- Today we will be hearing an update on the Social Health Information Exchange (SHIE). Also with some opportunity for discussion from Commissioners and Advisors. Before that, I am going to hand it over to Stephanie to cover announcements from OeHI to open the floor.

Stephanie Pugliese

- We are deep in our Health IT Roadmap Refresh work. We have had a couple of site visits and about ⅓ of our team is out on the road now. As a reminder, we are working with Healthcare providers as well as patients to try and capture the patient lens for this upcoming Roadmap. So we are really excited about that. We do have a few opportunities for folks to help us understand what the needs are out there. I will grab the links from our website. We are asking providers as well as Community Based Organizations (CBOs) to host listening sessions for us as well. We do have funding available for that as well as a lot of guides and materials. We are really excited about this and working more directly with communities to hear what the diverse needs are across the state.
- As far as updates for the Commission, as many of you may have seen, the Office of the National Coordinator released their updated Federal Health IT Strategy. We will be submitting a comment on that in partnership with some of our state agencies. We will be sending that around for Commission review and approval. It is due on May 28th so we will have it to the Commission a week before so that you all have time to weigh in and let us know what you think. Really exciting stuff and convenient for us to see before we refresh our state strategy. For awareness, there have been race and ethnicity data standards updated at the Federal level so we are wanting to work with the Commission to help get the word out to support providers and communities to collect this data to give us a better picture of how people are experiencing care. And with that, I will open it up for Commissioner announcements.

Commissioner Announcements:

- Jackie Sievers: I think that everyone in the room probably knows but Contexture and QHN

have announced that we are affiliated. That was effective last week and we are very excited about that. More information will be coming out about what that integration looks like and when that process is final.

- Misgana Tesfaye: I just wanted to let everybody know that we have hired a new Health IT Director for the Colorado Department of Human Services (CDHS). Her name is Shelly Pachiano. She started on April 15, 2024 and she is meeting with all of our health facility leaders and getting a lay of the land with CDHS. I wanted the Commission to know that she will be listening in on these meetings on a monthly basis.

Gabby Burke

- Gabby Burke, SHIE Lead, OeHI
  - For those of you who don't know me, my name is Gabby Burke and I lead the SHIE initiative here at OeHI and I will be co-presenting today with Colin Stauffer, the HHS Practice Leader at Resultant. I have been helping lead the SHIE architecture effort in partnership with Gabby and the OeHI team.
  - Gabby: We are going to be giving some updates about our SHIE initiative today. We are going to start off by talking about why we are doing this project. This is kind of a grounding and level setting moment.
- Why are we here?
  - Research has shown that social determinants of health, also sometimes called health related social needs or SDoH, account for over half of a person's health outcomes. This means factors like access to safe and affordable housing and nutritious food are more than twice as impactful on a person's health outcomes than their clinical care alone.
  - Currently, our social care delivery model is extremely fragmented. It is arguably one of our most fragmented systems. Data systems are often outdated, siloed, and can be hard for providers to navigate. Providers - and when we talk about providers in this context - we are talking about folks who deliver social care services in relation to the more medical provider model and they rarely have the information they need in one system to make informed decisions about their client's holistic health. Which means that at the end of the day, the burden of social care really relies on the person. People can be repeatedly screened for the same needs which can be traumatizing because sometimes we are asking folks to recount some pretty difficult periods in their lives over and over again. Folks have to coordinate their own care which can mean keeping track of multiple providers and fielding phone calls and emails which can be really difficult to manage and providers might offer duplicative referrals, clients may end up in services that are not a good fit for them. Providers might sometimes issue referrals to services that are not available or ones that their clients are not eligible for.
- Living Pre-SHIEcosystem
  - I really want to emphasize that these data silos that exist throughout the system disempower providers but they also disempower people. At the end of the day, we are trying to make folks' lives easier and simpler during some of the most difficult times in their lives.
- SHIE Vision:
  - Our overall strategy builds on regional and state successes with a core goal of meeting providers, care networks, and other partners where they are instead of imposing an entirely new technology solution. We have landed on a two pronged approach which funds a vendor agnostic ecosystem which is the statewide unified architecture or the SHIE architecture which we are calling the Colorado SHIE. This section of the work is what Colin will be talking about which is our work that we are partnering with

Resultant on. We rewarded Resultant through competitive solicitation for this back in November 2023 so it's been almost 6 months that we have been working together.
    - This model really focuses on connecting different data sources and focuses on interoperability, flexibility, and data governance. I want to emphasize that while Resultant has been awarded to develop the unifying architecture, they are really building out a data sharing ecosystem that can be transferred or scaled as technology evolves. It's really not meant to be one platform to roll them all and is not meant to be a one size fits all approach. This approach is intended to integrate with tools that folks are already using in existing workflows and it's a complimentary data architecture, not a stand alone competing referral platform. The second prong of this work funds regional infrastructure and partnership building for priority use cases. This will be funded through a competitive grants process that will be awarded through an RFA (Request for Applications) that will come out later this summer. The overall goals of these two prongs together are to increase interoperability and data sharing without forcing significant changes to the provider or social care provider experience where they already have workflows that work well for them. We really want to let providers stay in their preferred system of record, reduce administrative burden on providers and patients from that duplication of data entry that can happen very often in our current system, and to overall make it easier to deliver social care.
- Goals of the SHIEcosystem:
    - The goal of the ecosystem is to make it easier for providers to deliver social care and to integrate it into their workflows and to make it easier for folks to navigate the social care system. For providers, this means keeping providers in their preferred system of record as much as possible, reducing the administrative burden by reducing the amount of times providers have to tag into other systems to double enter data. It also means improving access to resource information so that providers know where to send clients without getting completely overwhelmed or having data that they don't trust. For clients, this means reducing the amount of times individuals are screened for social needs. These screenings can be really traumatic and can erode trust with care providers when folks feel that they have been repeatedly screened but that folks are not necessarily taking action around these screenings. Overall, with clients in particular, we want to reduce the amount of time they are spending on their own care coordination and repeating this information over and over again which could be available at providers fingertips with the right data sharing procedures in place. For Colorado as a whole, we hope to streamline our existing networks and workflows and to integrate state owned systems to make it easier to access and more transparent. We, as OeHI, want to emphasize here that we know the problems and we know how social determinants of health impact people and families so we are hoping that this framework and approach really starts moving us in the direction of actually building solutions for these problems. Data does not exclusively entirely solve the problem but it can start moving us in the right direction towards creating meaningful change for folks who have been historically left out of the system.

Colin Stauffer

- SHIE Architecture: Gabby talked about our mission and vision with SHIE but what is it actually going to do? At its foundation, the SHIE architecture is a data exchange. It is there for the movement of screening and enhanced referral information and to make social care delivery easier. We start by integrating shared data systems and bringing them into the SHIE architecture so that the other downstream systems can leverage that data without building the one off custom point connections that we are so used to. This improves security,

efficiency, and performance to help bring folks together to this modern data exchange platform. As we roll out solutions to meet the needs of specific regions, we don't want to be creating additional data silos and healthcare ecosystems. So as we are rolling out data systems to support those regions we want to make sure that they're integrated within the SHIE architecture so they are all part of this modern SHIEcosystem framework. Likewise, by building the SHIE architecture and service oriented architecture all participating can benefit from some of the capabilities that are within the SHIE such as data normalization, identity matching, transparent access controls, and consent management. We will make that available through an intuitive developer portal that folks in the public can have access to register and sign the legal agreement. Then you don't have to build up duplicative capabilities across the state.

- What CoSHIE is not: Sometimes it's helpful to talk about what SHIE is not. We have had a lot of conversations with different stakeholders. We try to work through how we can drive value and address particular use cases in the state. One of the things we want to hit on is that SHIE is absolutely not a closed loop referrals platform. It is not a replacement for your existing referral platform. It is a data architecture that helps close the referral platforms interface with each other and also lets us bring that data together so care coordination teams can see all the touchpoints from an individual level. SHIE is not a surveillance or research tool. SHIE is designed to understand and improve people's experience navigating the care ecosystem and store the minimum data necessary. It always comes back to SHIE is an exchange, it is moving data between systems that folks use on a day to day basis. Finally, it is not a replacement or competitor to other HIT solutions. SHIE is complimentary - it is not a competitor tool on the marketplace or other case management systems that folks may be using.
- What CoSHIE is: It is customizable and flexible. It is not a one-size fits all solution. It's componentized and allows people to meet them where they are. We allow for all different modalities of integrations to data exchange so whatever your system needs to be able to move or receive data, we try to accommodate that. CoSHIE is also a long term investment. This is a 10 year roadmap. While we are excited about what the CoSHIE can deliver, we are asking for some grace because it will take time. There is no single use case that is going to solve all of the social health needs for the entire state. Instead, we are going to identify use case by use case and by continuing to add more data sets into the SHIE architecture we are going to be able to identify and address unmet needs but it is not going to happen overnight. We are looking at use cases as syncing them out years into the future because data moves at the speed of trust. We are also vendor agnostic, modular, and modern. SHIE is designed to grow, evolve, and change over time to meet the needs of an ever-growing ecosystem.
- Use Cases: The things we are actually going to do to begin to move the needle as we piece use case by use case. We are adding more and more data sets and the more data we are exchanging, more of the picture we are making clear. We have begun to sequence out the first four waves.
  - In Wave 1, we are deploying the initial core architecture for the SHIE - our target is September of 2024. There are two specific use cases that we are focusing on. The first is accelerating home and community based service transition referrals - helping individuals in an institutional setting such as a nursing home. As well as accelerating the movement out into the community. We are also sharing individuals' housing needs with their care team.
  - Wave 2, we are targeting for Spring of 2025 and rolling out our SHIE portal, which is a portal for folks that don't already have a case management system or

extremely limited case management capabilities. Our goal is 95% usage of SHIE to the data exchange so that folks are continuing to work in the systems that they have today. From a use case perspective, sharing housing voucher status and this compliments Wave 1 where we talked about individuals who are at risk or experiencing homelessness and what services are they providing and how we are going to augment that information with the HUD housing status from DOLA. As you see, incrementally adding on data so that we can get a fuller picture. We are also going to be integrating our two in one community resource inventory so in the future we can have more efficient referral routing. We will be sharing Medicaid enrollment data with the care team for very specific and approved use cases. And also so folks know what they may be eligible for so that we can put them in touch with a care coordinator. We will also be continuing integration of housing needs data with care teams. So bringing the data in but also doing some hand holding so folks who might benefit from seeing homeless information and how they integrate that within their system. The last thing in Wave 2, which we will see in all our future waves, is to begin integrating the SHIE Regional Hubs and the systems rolled out for those regional hubs into the broader SHIE architecture. This will be an ongoing thing as these solutions come online.

- In Wave 3, we are targeting to be rolled out by Summer of 2025, we will be informing the care team of Medicaid member incarceration transitions. So if an individual is experiencing incarceration and as they are planning for discharge the care coordination team will be aware of this so that they can get them set up with their 30 day prescription or behavioral health specialist appointment before they leave. All the things we know help to allow them to have these folks know that this event has taken place. We will also be collating referral data from commercial closed loop referral platforms. We talked about SHIE not wanting to be a closed loop platform but we know we have multiple platforms and can SHIE be the way to bring that information in so that folks can see all the touchpoints in an individual way. We will also continue to integrate SHIE Regional Hubs as well as looking at exchanging homelessness risk assessment information from CDHS and other places where that information might start to be captured. Finally, sharing referrals to support justice involving individuals with mental health needs. Making sure the folks in the jails and correctional facilities have the behavioral health information to better serve their needs.
- In Wave 4, which is a little further out - Fall of 2025, we will be sharing social care referrals across platforms and then continuing to integrate the SHIE regional hubs which is ongoing. We actually have a lot of use cases that we will be working on next week to begin to prioritize the Wave 4 use cases. There are no shortages of ideas out there; we just have to figure out which ones we want to target for that Fall 2025 release.

Gabby Burke:

- Regional SHIE Hubs: Hubs are networks of organizations that share data through the SHIE architecture to improve the delivery of coordinated care. These networks can be formal or informal and they have to be organizations that focus on clients who are enrolled in or are eligible for Health First Colorado which is Colorado's Medicaid Program. In general, the structure for SHIE Hubs under this RFA (Request for Applications) will consist of an anchor organization who is actually awarded the grant and partner organizations. A region can be really flexible based on what the use cases might look like. The goals of this component of the program are to build upon those existing community networks within those regions that are

tailored to the specific use cases that a Hub might be working on. We want to focus on projects that have already been in place that have processes and workflows that work really well. The goal is to be equity first and person centered. We have developed this entire model to make sure we can engage community members in development of the SHIE knowing that there is so much great work going on at the community level in Colorado. We really want to make sure to elevate that work as opposed to imposing new technology solutions that would interrupt this great work that is already happening.

- Regional SHIE Hubs Structure:
    - As I mentioned, these can be formal or informal networks that might already exist or may be emerging and developing as this project is coming online. Also mentioned earlier, the geography is really flexible so we want to think about alignment with the other regional efforts that are going on across the State. It is not required to be entirely overlapping with those regions because we really want to think about the way that clients receive care. In rural communities, this might involve a number of counties or for Denver Metro, this might be broken down into neighborhoods or simply, part of the city. We really wanted to keep it flexible so folks can really take the time to understand how the clients in their area receive care. I want to mention that the hubs concept is meant to be complimentary to other existing integrated care community models. Hubs will be centered around an initial proof of concept to build data sharing infrastructure. The reason for this is to make sure that we tailor the prioritization of these data systems and these hubs to specific projects so that we can avoid the very overused phrase of boiling the ocean.
- There are four priority use cases that we are focusing on:
    - Supporting folks with disabilities
    - Increasing connecting individuals to safe and affordable housing
    - Reducing barriers to care for folks who are navigating substance use disorder
    - Reconnecting folks exiting incarceration back into their communities
    - These priorities overlap significantly. The reason we are asking folks who are proposing a hub is to be able to spend the resources it takes to build out partnerships and to deeply understand that client organizational experience. We are not asking folks to pretend like individuals in these communities don't overlap but trying to keep the workflow as targeted as possible so we can build out a meaningful infrastructure that can be expanded into other use cases as we learn.
- Eligible organizations:
    - This RFA is flexible to ensure that communities can choose a hub approach that works well for their particular needs. Most organizations will be eligible to apply to be an anchor organization (or primary grantee). The one exclusion is that for-profit organizations are not eligible to be a primary grantee. One of our core values for the SHIE initiative as a whole is to make sure that SHIE development is driven by community needs. We have earmarked funds specifically for Tribal Governments and Urban Indian Health Programs separately from the RFA process. The goal of that is to make sure that Tribal data sovereignty is respected.
- Blending and Braiding Funds:
    - One thing I want to highlight here is that we have had a really great opportunity to blend and braid funds on this particular RFA. We are really excited to be partnering with the Colorado Department of Public Health and Environment (CDPHE) to offer two separate tracks of funding within the RFA. The first is the proof of concept funding to build up the hub and that can build up data sharing infrastructure, data use agreements and governance, and care coordination workflow optimization. All of this is

shared hub level integration. That is an award maximum of $2,000,000 per hub for an initial 3 year grant period. We are excited to also be able to offer supplemental funds for technology for start up costs which is coming from CDPHE. CDPHE is able to pay for individual technology upgrades at the organizational level to make sure that barriers are reduced for organizations who might not have the ability to access technology at this point and would benefit from having those upgrades made into the hub.

- Regional SHIE Hubs RFA Timeline:
  - We have completed our initial drafts and we held a kick-off webinar on May 1st. Our goal is to post the actual RFA in late Summer pending all of our Federal approvals but we are releasing our RFI (Request for Information) on May 13th that will help us identify resources internally to make sure that the RFA process is supported. Participating in SHIE discovery or use cases does not impact folks ability to be a SHIE hub or to apply for the RFA.
- Parallel Initiatives:
  - Resource Inventories:
    - To ensure that referrals are accurately exchanged, we have been working on a parallel initiative to improve the interoperability of the various community providers and resource inventory that are already used in the community today. Overall, the vision of this is to make sure that folks are accessing resource data that they can trust wherever they get it. Folks that access their information in a provider directory through their insurers should have the same information available to them as folks who google “dentists near me”. This is really core to the SHIE architecture because we need to be able to accurately exchange referrals so we need to know what resources are available. As we move towards a model where social health is valued equally to other types of health, folks should be able to access social health information in the same place they may get provider information.
    - Our current state: We are really excited to be partnering with Mile High United Way to begin ingesting their 211 into the SHIE architecture. In the next phases we are developing an initial pilot that will use some AI methodology to normalize resource inventory databases. We are also following BHA’s lead on their OwnPath profile work which is in more of that provider directory space to start normalizing those directories.
  - Consent and Governance:
    - Consent: We are beginning to frame out organizational consent which is part of our consent management framework in alignment with the newly formed SHIE governance committee activities. Our consent team is also working on protocols for care provider consent. We are also developing strategies for accessing and sharing individual eligibility and enrollment information that is related to state programs. As an immediate next step to individual consent framework, we are mapping out the strategy in our Consent Roadmap and we are actively seeking feedback from the Consent Management Workgroup.
    - Governance: We are starting up a new data governance workgroup based on the feedback from the March Commission Meeting. We are also developing the data sharing strategy for SHIE partners.
- As we are approaching 6 months of development, I wanted to take a quick moment to deliver some good news. We have completed 100s of hours of discovery, we’ve worked with over 50 external organizations, developed this new governance model, initiated 8 new contracts, built out the new RFA, and built new relationships with several other state agencies. We also have

33 use cases in our backlog. I wanted to thank all of you for your input as this wouldn't be possible without all of the great collaboration we have had so far. And with that, this is the end of my content, I will pass it back over to KP.

KP: Let's open this up for Q&A:

- Mona Baset: This is amazing work and an incredible plan. I had a question about the timeline and what is driving that timeline as it looks like it is going to be a pretty extensive project. Are there big milestones along the way where we can start using the data?
  - Gabby: The first thing that is driving our timeline is that we are using American Rescue Act (ARPA) Funds for the first development phase. Our Wave 1 use cases that are coming out in September are all funded by ARPA. We have an official 9/30 deadline to spend those funds that are tied to the use case releases. We will have more to share as that progresses and as we get past the 9/30 deadline. I also want to mention, as far as the SHIE RFA goes, all of those hubs will be use cases of their own.
  - KP: Just to dig into this a little more. In the presentation - is everything you are identifying, year 1 and is it required for ARPA? What are the success for ARPA vs. success for us as we understand that there is a funding dimension.
  - Gabby: We have two initial use cases that are foundational to the ARPA funding and it's a little bit tricky because we are building so much of the back end architecture and it seems like the use cases might be smaller on scale but it is really sophisticated and exciting architecture. The first use case that we are building out is around community based service referrals. So when someone is in a long term care facility and it seems like the right fit for them to come back to the community, there is a referral process in place right now that coordinates their exit back with support from several types of agencies. We will be starting off by leveraging the SHIE architecture to make that process automated. The second use case that we are building out in this first pre 9/30 wave is to demonstrate how the architecture is functioning and to build out the architecture itself is ingesting data from the Homelessness Management System. That is the database that holds all of the coordinated entry data for the state of Colorado for folks who are experiencing homelessness and ingesting that through which will set us up for success in the following Waves.
  - Colin: I just wanted to add that behind the scenes, it is broken down into two components: Synthetic data generation or our data mesh and our interoperability layer, master person index. So there are a bunch of technical components that each have their own station that is tied to formal milestones in our project. So going back to Mona's question, yes - it is very granular in how we are building down the different pieces and we have to test each piece. When we talk about the architecture behind the scenes, it's a lot of interworking and a lot of complexity that we are working with.
  - KP: If I am hearing correctly, to summarize, ARPA timeline successes foundational architecture which has a lot of detail in there your two use cases are needed for initial rollout?
  - Colin: Yes
- Cory Hussain: Colin, for you, I love the map and the different ways that you described how the SHIE architecture is going to be and how it grows from a small concept to a large regional model. A couple of questions around that. Within each one of those deployments is where this can fall apart. The reason I'm asking about this is because I work in this environment. I know the data quality is only as good as the workflow process and for collecting this data. You are connecting some very different systems that are extremely complex including healthcare systems, community based organizations, community health partners, rural health providers. So have you looked at what the barriers might be and have a roadmap on how to address that?

- Colin: We have to look at it use case by use case. If you try to look at it across the entire ecosystem, it's impossible. Let's take the HMS data as an example. When you're digging in, how can that change data from a technical perspective? What data do we think is the most complete? There are certain fields within the HMS system that are mandated by HUD. Those typically have to be filled out so should we prioritize those data points before other data points that might not be as common. As we are going through and looking at those types of considerations, we want to make sure we are sharing data that people feel confident in because as you start sharing incomplete data, people lose faith in the whole project overall. We are being very purposeful in what we share and that they know what to do with the data. The other thing you mentioned, Cory, is what are some of the fears that I have. One of them is that we can go and consume and make all this data available but folks have to consume it and populate it in their system and we don't have control over that. That's why we really talk about use cases and trying to find incremental value with the partners that we are working with so they are incentivised to share and use the data.
- Cory: Are you going to be using the train the trainer model, which we tend to use a lot?
    - Colin: Yes, it makes so much more sense when you can give folks a real example. With the homeless data, people say that they would love to have HMIS data but who can actually take action on that? We are trying to work closely with folks who are tasked with helping with outcomes for the Medicaid population. That information is something they can directly take action on. So the question becomes, how are you going to take action on that? Once we can build that use case to show how other folks are effectively able to use that data with the right "DUA" in place, another entity could consume the same API and understand how to leverage that data. That is why it all comes down to the right use cases.

- Micheal Feldmiller: This is definitely a complex project with a lot of moving pieces. I am curious if you've talked about maybe developing some sort of dashboard or a data visualization that could be shared with the commission that would track project milestones? I think it would help a lot of others want to come and participate in this.
    - Gabby: Yes, we are planning to build out a dashboard that will display visually what we have. We are also with a company called The Greystone Group to help build out an evaluation strategy for this entire project. So having that external lens to help us to develop key evaluation questions, build out some more comprehensive metrics, and to define what success looks like over the 10 year period - because this is a very complex project so more to come there. But we do have that strategy coming down the pipe and will be ready for sharing before June 30th.
- Amy Bhikha: This was a great presentation and I know there is an amazing amount of work going on here. One of the things I have been thinking about is that whole ecosystem of data sharing agreements. How are you coordinating the data sharing agreements? What will that look like?
    - Karen Haneke: Right now we have started up a SHIE Data Governance Committee for the State. At the moment, it is primarily HCPF members but we also have some folks from DOLA and CDPHE on that. In the next meeting, we plan to show our strategy to include an enterprise memorandum of understanding that partner organizations will agree to those specific standards and then entities sharing data will sign a data sharing agreement - it will either be a third-party template or using the state's approved interagency agreement template. For folks receiving data, they will sign a data use license and within the context of those specific agreements and licenses, we will list

out the terms of that condition. We are looking forward to getting the feedback from this committee next week.

  - Amy: Are you putting the data into inventory or quality components into that governance roadmap?
  - Colin: One of the components of the architecture is a data dictionary using Google's data plex tool to populate the data associated with data so it is absolutely associated with the Roadmap. One thing I will also add about the DUAs is in addition to all the great work that Karen and the governance team are doing is that we are going to store all the relative DUAs within SHIE which will be tied to access controls. This is part of the Roadmap and the technical approach.
  - Cory: Will you be using CDA architecture or will you be using FHIR (Fast Healthcare Interoperability Resources) resources which is way better?
  - Colin: In our first Wave of use cases we are not going to be sharing a lot of true healthcare data which is what FHIR mostly focuses on but when and where it becomes applicable, FHIR will be the standard. Mostly what we are looking at right now is aligning with the gravity project and their standards around SDOH (Social Determinants of Health) data types.
  - Cory: The only problem with a lot of organizations that aren't using the same tool to collect the data is making sure that people can map their questions to the right LOINC (Logical Observation Identifiers Names and Codes) codes that we are going to be transmitted.
  - Colin: We have to decompose every assessment because there are endless assessments across the state at this point. We have to decompose them, map them to LOINC codes, and maintain them. We will try to normalize but it will never be perfect.
- KP: A question back to Gabby and Colin is that clearly this group is deeply experienced with this matter so we are getting some great questions today and I think that it is part of the role of the commission as we move to executing this. How else can the commission be supportive, not just in this, but I think to Michael's point earlier is that this is only as good as it's used. So how can the commission support your process?
  - Gabby: One of the things that keeps me up at night is thinking about how this is a 10 year project and a major change to the way we exchange data in Colorado. I want to make sure that we keep momentum going and that folks stay engaged and stay on board with us as we go through this major development process. If there are areas where you all are not getting the updates you need or if you think more information is needed we definitely want to hear that feedback. Your partnership and engagement on this project is really critical and really valued.
  - Colin: First, talk about SHIE. Go talk to the people that you engage with and make sure they are aware of it and make sure they understand it. I think the team has done a great job with the newsletter and the publicly available information. No matter what, it is a complex project so some folks may be out there that aren't as engaged because they aren't exactly sure what the SHIE is. So my ask of this group is to go talk about SHIE and make sure that folks understand what it is and that they aren't holding on making investments in things that are complimentary in what we are trying to do. Secondly, if you see specific use cases where you think the SHIE is a great fit, let us know. We are constantly talking to people and asking them how can SHIE help? As you are out there having those conversations definitely let us know very specifically where you think SHIE can move data from this place to that place to help drive that outcome. That information is invaluable for us as we continue to build out our use cases.

- Stephanie: I think from my perspective, Gabby and Colin are spot on and I think the other thing is that the commission is OeHI's advisory board so we really welcome hard questions and asking us to clarify if we aren't being clear. Asking questions can be in these meetings or we are happy to set up other meetings to discuss any of your questions. We truly want this to be all that we've explained it to be and what we have hoped that it will be. Again, I just ask all of you as the leaders that you are to ask these questions of us and don't be afraid to tell us if something seems off or not in line with what the vision is here.
- Cory: Everyone thinks about SHIE as unidirectional where the client is sending the SDOH issue and then transferring that data to a CBO (Community Based Organization). The close the loop process where the person is provided that resource with that information flowing back in a standardized fashion to organizations that are referring or have recognized their own clients requiring that resource and studying the impact of that. Improvement in mental health, improvement in healthcare utilization because that is where the ROI really lives in terms of the SHIE and as a state we can measure that impact. For example, if we spend $10 in trying to provide that kind of a resource to patients or a client we save $120 and it creates healthcare utilization by improving a long list of health conditions. I think that is what everyone has thought of as one direction in data normalization but it's the opposite direction. And maybe we can lead that work by developing our own standard on the other end.
- KP: I think that is spot on, Cory and is a new space nationally because there really aren't many SHIE's - we are one of the first. I think that as you have been hearing one context of evaluation as more tactical and getting this out the door during performing and ensuring that it's performing right during the data increasing from baseline and is being transacted we can get more partners. The big thing is how this improves lives - the metrics you are talking about also help justify future funding for the SHIE. So if you aggregate that to the state level, you're able to show 80% of what drives health outcomes for SDOH. We know that there is a financial ROI and that justifies continued funding. The question is, in terms of success for the SHIE, if you were doing an evaluation, is that approximate metrics or is that a direct metric for the SHIE. Everyone has an interest in that, otherwise, we aren't going to have a way to justify its future values. This has been a great conversation. Any other comments or thoughts here before we move on? I know this is the first of many so this is going to be a continued discussion. I appreciate everyone's engagement and Gabby and Colin, this was a great presentation and I'm sure you will be hearing from colleagues and commissioners and we are all looking forward to supporting you all in this process. With that said, I'd like to move to our public comment period.

Public Comment Period

- KP: Have there been any public comments today?
- Stephanie: We didn't have any submitted beforehand, so just Lisa's question:
    - Lisa Blake: You could start recognizing them publicly for their use and action of the system and participate in improving their clients outcomes. Would SHIE be a good starting point for a grassroots organization?
        - Lisa: Because of the lack of whole person care, I do work with the addicted population, homeless population, and the underserved population. In that work, exactly what you guys are talking about is the biggest problems we have with getting our persons off the streets and into adequate housing and the systems just don't meet each other. A group of people are coming together and are going to put together a 501c3 that would bridge job skills and employment and

training along with sobriety guards along with holistic healthcare. Those are the three areas that when you don't have Medicaid yet and you're treating yourself. I've been wondering if there is any kind of a system out there that would be considered grassroots if we put this together - we are not affiliated with the state in any way, shape, or form - just the workgroups I am in. So, if we were to put this together, would this be an appropriate data system to utilize to help our people go from where we are at to get them hooked up with state resources and then actually get further into the housing, nutrition, and the more social care needs.

- Gabby: Thank you for sharing and I can give some insight but want to continue the conversation. I think the RFA is a great fit for organizations like the one you are trying to stand up. We really want to elevate the work going on at the community level. One thing that could be of interest to your group is based on feedback from our webinar on May 1st. We are going to be making available the opportunity for folks who apply to the request for information that is coming out on Monday to have their information shared with all their applicants. Smaller organizations will be able to have their contact information listed so they can get plugged into a larger hub or a hub that works to their geography to build out their network of different organizations that might be working with the same population that you are. That might be worth exploring and that will be posted on our website and we will be putting this out there for informational purposes because it is a competitive RFA. We will have that information shared so that you can connect with other organizations and hopefully that will help facilitate information surrounding the upcoming grant program.
- Lisa: Thank you so much, I feel so encouraged.
- KP: Thank you Lisa, that was a great question
- Cory: There are going to be a lot of organizations that are starting from the ground and I think one of the things that OeHI and the commissioners need to be cognizant of is developing mobile solutions. I read this whole project from the UN about how they dealt with the ebola outbreak and how they gave information out on people's cell phones. They were able to connect the organizations through that. I think as we are developing the SHIE, we should be very mobile.
- KP: Thank you - that is a great point. Any other questions or comments? Announcements from commissioners, anything? Stephanie, back over to you.

◦ Stephanie: We did want to ask the commission for our June eHealth commission meeting which is scheduled for the second Wednesday of the month, which is the 12th. Due to some vacations and out of office schedules for our commission leaders, we were wondering if folks would be willing to potentially move commission to Wednesday, June 5th at that same time. We do need to have as many folks as possible because we will be doing our legal training. So if you can give me a hands up if that works or tell me if it doesn't work. Maybe unmute and let me know if it doesn't work. I can follow up via email as well but wanted to give the commission a heads up that this request is coming.

Action Items

- *Next meeting TBD*

eHealth Commission Meeting Closing Remarks

- KP: Thank you - this has been a great meeting and this comes to the end of our agenda for today so you'll hear from Stephanie regarding the update on the date. I hope that can work for most of us. Thank you to everyone for having a great conversation - we really got some great information on the SHIE and where we are going with that.

Motion to Adjourn

KP Yelpaala

- KP Yelpaala requests motion to adjourn
- Parrish Steinbrecher motions to adjourn
- Krystal Morwood seconds the motion