OeHI
Office of eHealth Innovation
eHealth Commission

Meeting Minutes

October, 12th 2022 | 12:00pm - 2:00pm | Virtual Meeting Only

Type of Meeting	Monthly eHealth Commission Meeting
Facilitator	KP Yelpaala, *eHealth Commission Chair*
Note Taker	Jenna Randolph
Time Keeper	Cierra Childs
Commission Attendees	Amy Bhikha, Micah Jones, Arthur Davidson, Misgana Tesfaye, Chris Wells, Jason Greer, Jackie Sievers, Parrish Steinbrecher, Rachel Dixon, Toni Baruti, Wes Williams, KP Yelpaala, Michael Archuleta, Sophia Gin, Mona Baset, Patrick Gordon Not in attendance: Kevin Stansbury

Call to Order

Kaakpema "KP" Yelpaala, eHealth Commission Chair

- Roll call was taken. 13 Commissioners present.
- Corrections: Art Davidson: in August minutes-error in his name and fix “payer” systems to “paper” systems
- In favor of approving: September approval of minutes: Davidson and Tesfaye motion to approve
- Opposed: N/A
- Next month we will approve August minutes

OeHI Updates-eHealth Commission Updates

KP Yelpaala

- Today we have a really great opportunity, as there has been a lot of conversation about health equity over the recent months, particularly around data. I have been working with the American Medical Association (AMA) and they have a team focused on equity and data. We have invited their team to our commission meeting to provide some insight into how that looks and what they see as best practice and will be giving us some guidance to what we see here in Colorado.

Rachel Dixon:

- The second Colorado Provider Telehealth Survey is still open
- Last year we did this survey and had an amazing response of about 1,300 all across the state from every county and provider type.
- That data was used by Office of eHealth Innovation (OeHI) and Health Care Policy and Financing (HCPF) along with many other organizations to inform policy decisions, funding, and the Health Information Technology (HIT) roadmap.
- A year later we are doing this again and it is open until 10/25/22.
- Providers and administrators that respond are entered to win 1 of 3 $100 gift cards and we would really appreciate your support in spreading the link in the slides.
    - **Question from Wes Williams-** If you hypothetically worked for a company where we have 500 people offering telehealth services, would you want all employees to respond? What are you looking for here?
        - Rachel Dixon: We will be able to see what organization the responses (participants) work in from the survey questions and structure. The survey includes provider sentiments in terms of what additional resources and opportunities they need to improve their internet connection especially for our

rural providers.

- Some of the results from last year's survey included:
    - Providers stated they could not identify what the resources available were, there were 28 different organizations offering telehealth 101 training.
    - There was a gap in timeliness, accuracy, as well as format delivered and providers in general expressed they felt like they needed more resources.
    - In advancing telehealth, providers have seen many of the same types of questions, surveys, and training in our materials and completing projects in the same space or organization.
- OeHI worked with us to develop a logistics plan and a beta version of a CO Health Innovation Resource Platform. This is identified as a priority in the Roadmap and recommended from last year's survey.
    - This will explore how to make it easier for people to find funding opportunities, grant writers, and resources to apply to funding opportunities.
        - Collaborative spaces to share resources, etc.
        - Centralized hub for training, webinars, events, grant opportunities, resources, toolkits for provider organization and health orgs

Stephanie Pugliese: The last opportunity is the Dollar to Digitize grant opportunity and that is to provide funding to home and community-based providers to digitally transform their care delivery and investments in technology and upgrade their infrastructure

Data Equity: Collecting, Interpreting, and Presenting Race and Ethnicity Data - Fernando De Maio, PhD

KP Yelpaala: We are pleased to have the Vice President of the Health Equity Research and Data Use Center for Health Equity at the American Medical Association, Dr. Fernando De Maio.

Dr. Fernando De Maio:

- To explain our work in equity I will begin with the Land and Labor Acknowledgement and the larger struggle for justice.
- I'll be covering three main points-
    - Consensus-it would be unethical to continue to merely describe health inequities without really good data going back decades and decades to really give us a magnitude of the whole problem;
    - Prioritization of explanations and interventions focused on "beliefs, behaviors, and biology" of all individuals; and
    - The need for historically deep and geographically broad understanding of structural violence and the root causes of health inequities. Of which require greater clarity on language and narratives, including narratives around race.
- All of the work the American Medical Association (AMA) is working on is published in two documents:
    - The first, published last year, Organizational Strategic Plan to embed racial justice and advance health equity, proposes a nation where systems and resources work well and are equitable. And all physicians are equipped with consciousness, tools and resources to confront inequities and racism.
    - Another resource, *The Guide to Language, Narrative and Concepts* published with AMA and Association of American Medical Colleges (AAMC) Center for Health Justice.
- A key example is the collaborative work with AAMC, Accreditation Council for Graduate Medical Education (ACGME), and AMA; we are working together to establish our best practices for data sharing and standards for sociodemographic data, including race and ethnicity, sexual orientations, gender identify, language proficiency, disability, and more.
    - These efforts will enable meaningful research not just internally but with other stakeholders and partners to better understand the dynamic of the physician workforce continuum. We understand our work cannot be done in a vacuum and must be collaborative across the healthcare ecosystem.
- We know that these data matter, that they are literally a matter of life or death. These data

are critical components to better understanding and overcoming the structural barriers to all aspects of the healthcare ecosystem. Our need is dire as Dr. Ehrenfeld stated last year; the actual workforce diversity does not make up for the racial and ethnic diversity of our patients.

- We come to this work mindful of AMA's own history and the power of data that can cause harm.
    - Example: medical directory from 1906 where col (for colored) was next to the names of black physicians, this was protested at the time as something that was discriminatory against physicians of color across the united states.
    - This discrimination and the harm it caused is described in the book, *The Racial Divide in American Medicine*.
    - We approach this data particularly around race and ethnicity with great respect, there are discussions across health care and work by many organizations to ensure physician networks are diverse and appropriately align with the patient populations.
    - This data can be used to track progress across time to hold accountability for creating diverse networks that meet the needs of our communities.
    - Yet the dangers are severe as Nancy Kreger warns us in her recently published article, data can be used to hide or perpetuate injustice.
        - Historically, designations of our physicians' races have been used to discriminate and exclude.
        - Modern use of directories we must be aware of and search for strategies that value the benefits and unintended harms for both patients and physician workforce.
- In Nancy Krieger's article she displays a sword as it symbolizes the double edge nature of the sword. Edge 1 is no data and edge 2 is equally bad; where problematic, “bad”, data gets edged into our systems and enables discrimination.
- Examples of this include the [Advancing Health Equity Health Equity Tracker]() where we know that data can be flawed and worsen health inequities if not reported or analyzed correctly.
    - Structural racism creates health inequities and leads to missing data. The maps and tables include our best data but have gaps and we know this to be true with COVID.
    - One of the most powerful reviews has been raised by the Urban Indian Health Institute on data genocide of American Indian and Alaskan Native COVID-19 Data; the state level analysis is powerful and important language to address the data genocide happening which is adding the the data and health injustice.
- Similar to the work Harris did in 1926, the book *Unequal Cities* takes a look at death gap data in the U.S. The data shows from the largest 30 cities that there is a 10 year gap between the healthiest and the lowest life expectancy rate. We compared this to the difference between white and black Americans and found the largest gap in Washington D.C. with over 12 years, El Paso has a black advantage and Chicago has a gap of 8 or 9 years and has increased every year for the last 5 years. This data shows us these rates are dynamic and vary from place to place and across time.
- These are two papers published last year in time and health affairs. We counted how many times racism appears in medical journals.
    - When comparing the major journals there was an uptick after 2020 in the use of the word “racism” following the George Floyd event. The data showed the use of the word wasn’t used in areas of data, but articles not in empirical science.
    - The American Journal of Public Health (AJPH) reported that 60% of the use of the word “racism” was noted in empirical studies, but does not mean they were studying racism. In scientific journals this number was very low and we are very underdeveloped in the research around racism in medicine.
    - If we as medical and health professionals cannot name and confront racism as a cause of racial health inequities, it affects what the broader public knows and doesn’t know about the racial distribution of health and disease and its social causes.
    - It is a dire time for world's leading medical journals to name racism and publish data and evidence on how it harms health and how dismantling of racism will prevent racial health inequities.

- **KP Yelpaala**: We can really collaborate on what this means for Colorado and for our Roadmap;

our first object in our roadmap is to support health equity reached through data.

- **Question from Parrish Steinbrecher**: One of the things we are advancing on is the cloud and unstructured data and there are data scientists making sure data is normalized, structured, and means what it is supposed to mean. Have you looked at the future of data structure and data lakes ensuring equity oversight? Is there in the process and for the user?
    - **Fernando De Maio**: There are overarching principles in my area as well as other similar areas to particularly monitor for unintentional harm and that is the crux to this situation and to health inequities that there must be continued efforts across organizations to monitor this.

- **Question from Toni Baruti**: Demographic data has always been an issue especially if you are an organization receiving funding for different sources. There is no standard list. How would you suggest standardizing that category's data?
    - **Fernando De Maio-** Across organizations we see slightly different standards were causing confusion and source data weren't matching. Categories change as well over time. The categories themselves are dynamic and change over time in response to societal needs. I'm not sure we are in the position to only have one as we look at different sources like census. These categories are complex. To answer the question we do not have a standard but we recognize the unintentional harm from the multiple categories.

- **Question from Toni Baruti:** What would be the most inclusive in your experience of categories?
    - **Fernando De Maio**:We at AMA implements the AAMC reporting and collecting standards, thinking they have the best approach. They do not have Middle Northeast or African categories out yet but they are doing a pilot of what that might look like. HL7 has other interesting categories with American Native Tribes which is also something we are looking at for great examples that is very comprehensive.

- **Question from Rachel Dixon**: We work with small budget limited provider organizations and a challenge they face is if they haven't collected a lot of data within their electronic health record (EHR) or they did not have quality data control tools which has created a lot of barriers to even getting a data set. A lot of the data sets they may have access to cost money or there are other barriers; is there any advice on where to start for these small organizations?
    - **Fernando De Maio:** We cannot depend on individuals to do this on their own; we must look to coalitions, partnerships, and stakeholders that we can move collectively or data will remain unfragmented with gaps that add up to a lack of clarity.

- **Question from Karen Shimamoto**: Can you provide us with your operational definition of racism that you use? How can health professionals be more intentional about engaging in research practices in health care?
    - **Fernando De Maio**: We look to Camara Jones and her breakdown of the 4 levels of racism, institutionalized,systemic, personally mediated, and internalized.
        - We built a module at the AMA hub that may be of interest to review the historical foundation of racism with COVID where we talk through the typology of racism and show how it advantages some and disadvantages others.
        - Your second question, it requires support around our publication processes and cultures. More and more journals are pushing back on the idea of race as a risk factor. Hopefully there will be more examination of the system of oppression and opening up this space to address this issue with positive intention in more conversations.

- **Question from Art Davidson**: Referring to the Embed Racial Justice Advance Health Equity plan, where do you think in the country you have seen good progress to see this effort from AMA? Are we actively addressing this or reviewing the language and data? Are there any sites we can look to for progress in confronting inequities?
    - **Fernando De Maio-** There are large segments of health and organizations that still

struggle with acknowledging racism as a health issue, more work and shifting the view from race to racism needs to be done. There are very well documented issues still present of current racism such as earlier this year when neo-nazis were marching. There have been advances as well as push back and that is how white supremacy works.

- **Question from Art Davidson**: As you state on the slide: all physicians are equipped with the consciousness, tools and resources; does AMA have any way to measure this? How can we determine providers have made advances in these three areas?
    - **Fernando De Maio-** We do not have set standards to measure this, or a large cohort to determine or measure how consciousness and attitudes change overtime. This is a gap in our knowledge, what we do know is how publications have used this language more and students have pushed for this. The Center for Health Equity would not exist without the support of delegates. We can also recognize the generational shift that health care has been unethical and unjust in some ways and should be improved.

- **KP Yelpaala**: The state of MN is making progress in policy reform around this, where state policy and Medicaid have seen changes around health equity and racism. Part of this is looking practically at implicit bias in the EHR. There are groups, mainly hospital groups, that can show how physicians are making implicit bias decisions in the EHR. The problem with this is how it is documented in EHR now and with whom this sensitive data is shared. At an individual health care system there are large health systems that are starting to measure this by looking in EHRs, applying data, and noting how they can apply AI and machine learning.
    - **Fernando De Maio**: We have been seeing this in medical records which I think is very profound. I would add the changes in the professional industry and the race-based resources and analysis that are coming out and being acknowledged and dismantled.

- **Question from Wes Williams**: Things have been focused on what as a provider we can do, implicit bias and build in structural racism practices, as well as research or lack of it on racism. With the eHealth Commission we need to consider what infrastructure we need to apply at the state level to build an equitable network of care across the state. We have heard capturing standardized data is important and assembling a provider directory and understanding how care coordination works. Are there categories of initiatives in terms of building out our state technology efforts to expand on our health equity efforts?
    - **Fernando De Maio-** We would like to see a fuller story of how health equity has changed over time such as an analysis of geographical racism to help us in outlining historic redlining and policy that has changed our lives over time and has been absent from our data.

- **Question from Rachel Dixon-** We recently worked with other partner organizations, a health equity cohort of health organizations in CO, and the feedback we received is that a lot of the health equity work is theoretical, as organizations lack confidence and direction. At the state level in 2020, racism was declared a public health emergency; however, we haven't seen intuitive examples. Have you seen any initiatives that have been effective?
    - **Fernando De Maio-** There is a great paper that walks through the four different areas and domains such a social divers of health, workforce, and other key pieces that is based on and founded on anti-racism and brings down those lofty ideas to more concrete actions and data for healthcare.

- **Question from Jason Greer**: Have you spent much time digging into the environmental aspects around racism? How are we looking into monitoring systemic racism as something happens and ensuring those people are represented?
    - **Fernando De Maio-** As a field particularly in health care and public health we have lots of work to do on big issues that we haven't integrated into the work yet.

- **Question from David Aylward-** Are you seeing if people are taking their information systems and altering data to address people instead of how to run the hospital or other system more

efficiently?
  - **Fernando De Maio-** I would review the health equity tracker at the Morehead School of Medicine, it has the most rigorous analysis of structural racism and structural violence of within data. We have more data in the world than we ever have but we have not yet come to find the best ways to add to systems.

- **Question from Micah Jones-** Is there anything that can be done at the health information exchange (HIE) level to address implicit bias or the data being interpreted?
  - **Fernando De Maio-**The challenge is always how do we find the best way to interpret our data to see differences between and group we are comparing.
  - **Wes Williams**: One of the fundamental pieces here is we need to collect data in order to understand the impacts racism has on health. An HIE has key components such as health information index which can show us basic demographics and we could use this HIE as a hub for important information about demographics and how they impact quality of care.
  - **Toni Baruti**: Those involved need to ensure it's inclusive, and that we have people from diverse backgrounds. As we are picking certain variables and standards we must do this from an equitable lens.
  - **Jackie Sievers-** We are currently working on improving the amount of data and how we collect it. I am interested in what goes back to a provider and what information could be useful.
  - **Micah Jones-** Contexture is also working on improving data and heavily focuses on demographic data to show use cases.

Comments on Health Equity Presentation

KP Yelpaala: The purpose of this conversation is to anchor us around our why and think about what the implications around this are.
  - We need more and real gender and race data to what end?
  - What questions do we want to answer, we need to be able to measure what is success and where we are today in terms of data and over what period of time?
  - This is giving us a foundation to set an objective that is measurable and can help us reach our goals and address our roadmap.

Stephanie Pugliese: These speakers are helping us to see what's going on nationally and internationally and what we can do here. I am involved in a health equity fellowship with AMA currently as well.

Rachel Dixon: We need to improve demographics and in terms of our patients we need to be doing better demographics of our workforce to better serve our communities.

Chris Wells: I wanted to bring to everyone's attention from CO Dept of Public Health and Environment (CDPHE), that last year HB22-1157 was signed into legislation , the utilization of demographic data to address health and equity, it is requiring us to look at all our health systems to develop standards for collecting gender identity, race and ethnicity.
- By November 1st we are looking to develop a health advisory group in collaboration with the Health Equity Commission (HEC). We will be presenting to the HEC and to bring forth standards of categories for our 150+ systems.

KP Yelpaala-How does CDPHE see their role in the interoperability space and filling those gaps? How can they gather and report on that data for more interoperably?
- **Chris Wells**: As we continue work in the HIE we are reliant on providers and upstream data components such as in COVID, we rely on EHR for data in the space so we want to be able to inform what information we need from them.
- **Art Davidson**: I wanted to better understand what HEC was? Other agencies have their own view on race, how is the work CDPHE is doing relate to human services and education? How do they relate statewide?
- **Chris Wells**: There are health equity seats on the HEC from other health organizations around

CO. Part of the work they do is report on findings and report back to the other organizations.

- **Jason Greer-** Not every health equity analysis gets stopped at the race and ethnicity barrier.
  - Earlier in the year when reviewing the Federally Qualified Health Centers data to focus on race and ethnicity and on maternal and child mortality, in this data there were gaps in the maternal and mortality data.
  - When it comes to getting data out of the state it's important that we are connecting it through Identity cross reference and unique IDs to improve their data.
  - **Wes Williams-** What is the role of big data and structural data and tying that into the evaluation research team and its diversity, equity, and inclusion team? When we gather all of this data there is a potential mapping system where we build this data that can be used dynamically to identify structural racism. Setting standards for categories would improve how we can use this data for more benefit and targeted intervention. We look at gender for example and how the definition has developed and changed through the years and we need to be able to build a system that can account for these cultural changes and eventually social justice work within healthcare.

Public Comment Period

- **Anonymous:**What is currently being done within systems to improve the completeness and accuracy of data that enable these analyses? How can we ensure data is collected respectfully in ways that do not cause harm?
  - **Stephanie Pugliese**: This was covered earlier by Toni Baruti, if you do not think your question was answered feel free to reach out and email our state email inbox.
- **Anonymous**: Is the use of Z Codes in ICD-10 starting to broaden the concept of health to include social factors?
  - **Art Davidson-** Z codes in ICD-10 are used to identify social determinants of health in data. The gravity group has spend time working through multiple social determinants of health domains and as part of that work they have made recommendations of Z codes to ISD10 and they have been accepted by ISD10 in some of those domains and continue to make recommendations as ICD-10 work in 18 different health domains.

Action Items

KP Yelpaala

- *Next meeting November 9, 2022.*

eHealth Commission Meeting Closing Remarks

- Open Discussion

Motion to Adjourn

KP Yelpaala

- KP Yelpaala requests motion to adjourn
- Tori Baruti motions to adjourn
- Parrish Steinbrecher seconds the motion
- Meeting adjourned at 1:50PM MST